Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Thrumble a prisoner at HMP Rochester on 18 April 2018

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

Our Vision

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

Our Values

We are:

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

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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

Mr Lee Thrumble died in hospital on 18 April 2018 after being found with a ligature around his neck at HMP Rochester the previous day. He was 26 years old. I offer my condolences to Mr Thrumble's family and friends.

Mr Thrumble was recalled to prison on 2 January 2018 and sent to HMP Elmley, where staff monitored him under suicide and self-harm prevention procedures (known as ACCT) until 20 February. He was moved to Rochester on 2 March.

The investigation found failings in the way staff managed the ACCT procedures at Elmley. Also, staff at Elmley did not pass on relevant information about Mr Thrumble's risk of suicide and self-harm, and his mental health, to staff at Rochester when he was moved there. Mr Thrumble's reception screening at Rochester was also inadequate.

I am also concerned that healthcare staff did not hear the medical emergency code called over the radio network when Mr Thrumble was found, because of reception problems. This led to a short delay in healthcare staff attending, though I am satisfied this did not affect the eventual outcome for Mr Thrumble.

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 2020**

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Summary

Events

1. Mr Lee Thrumble was recalled to prison custody on 2 January 2018, after being convicted of criminal damage, and sent to HMP Elmley. He attempted suicide at the time of his arrest and was on constant watch at the police station and at court.

2. At Elmley, staff monitored Mr Thrumble under suicide and self-harm prevention procedures (known as ACCT) from the day he arrived until 20 February. He was allocated a mental health worker who met with him three times. She referred him to a doctor to address his anxiety, depression and sleeplessness, but he failed to attend a triage appointment with a nurse on 2 February. The mental health team also referred Mr Thrumble for a psychological assessment and psychological therapy but he had neither while he was at Elmley.

3. On 2 March, Mr Thrumble was moved to HMP Rochester. He was seen by an officer for a reception screening when he arrived, but he did not have a reception health screening until 4 March.

4. From 14 March, Mr Thrumble received negative warnings about non-attendance at work. He was also suspected of being under the influence of illicit drugs on two occasions. On 16 April, he was sacked from the servery due to his poor attitude and because he was suspected of using illicit drugs.

5. At around 3.00pm on 17 April, Mr Thrumble disobeyed an order to return to his cell. He was agitated and wanted to know why he had been sacked from the servery. Staff restrained him and took him to the segregation unit.

6. At 4.20pm, an officer saw that Mr Thrumble had tied a ligature around his neck and attached it to the leg of his bed. Staff immediately cut the ligature, called a medical emergency code and started cardiopulmonary resuscitation (CPR). A healthcare assistant arrived with oxygen within five minutes but did not take an active part in the resuscitation. Two other members of healthcare staff arrived with the emergency bag around five minutes later and assisted with CPR until paramedics arrived at 4.39pm. Ambulance staff resuscitated Mr Thrumble and took him to hospital but he died the following afternoon.

Findings

7. We found that staff at Elmley did not pass on relevant risk information to Rochester when Mr Thrumble was moved there, including that ACCT monitoring had only recently been stopped. Staff at Elmley also failed to pass on relevant information about Mr Thrumble's mental health care, including that he had not seen a doctor about his anxiety and depression, and was awaiting a psychological assessment.

8. We found failings in the way the ACCT procedures were managed at Elmley. The ACCT assessment interview was a day late, case reviews were not multidisciplinary, the ACCT was closed before all caremap actions had been completed and there was no post-closure interview.

9. When Mr Thrumble arrived at Rochester, he did not have a reception health screening until two days later. The nurse failed to refer to relevant information, basing her assessment solely on Mr Thrumble’s answers, which did not always correspond with what was held in prison records.

10. We consider that there were signs Mr Thrumble’s mental health was deteriorating at Rochester and that staff missed opportunities to identify and manage Mr Thrumble’s risk and to offer him appropriate support. Although he had an allocated personal officer and an offender supervisor, we found that potential risk information was not appropriately recorded, shared or acted upon.

11. There was no appointed medical responder on duty and the two suitably qualified nurses tasked with responding to an emergency were engaged on other duties. One nurse did not hear the code blue due to intermittent problems with the radio reception, and the other nurse instructed a healthcare assistant to attend the emergency while she stayed behind to lock up medication. Although these factors resulted in a slight delay in healthcare staff responding to the emergency, we do not consider that this affected the eventual outcome for Mr Thrumble.

12. Staff failed to follow their own substance misuse policy when Mr Thrumble was suspected of being under the influence of illicit drugs.

Recommendations

- The Governor and Head of Healthcare at Elmley should ensure that, for prisoners transferring to another prison, staff should:
  - set out all relevant information about the prisoner’s risk of suicide and self-harm in the PER, including recent ACCT closure, in accordance with the guidance contained in PSO 1025; and
  - pass on relevant information about the prisoner to the receiving prison, especially for those with mental health issues who may be at risk of suicide and self-harm.
- The Governor and Head of Healthcare at Rochester should ensure that reception staff are aware of the guidance in PSO 3050 and that newly arrived prisoners are managed in accordance with PSI 07/2015: *Early Days in Custody*, in particular that:
  - reception staff examine all available documentation on the prisoner and consider and record all known risk factors for suicide and self-harm;
  - reception staff are appropriately trained on the ACCT process and how to spot signs of risk of suicide and self-harm;
  - prisoners are not moved onto a general residential wing until they have had an initial healthcare screening, other than for exceptional operational reasons which must be clearly documented; and
  - every prisoner is offered a general health assessment in the week following first reception.

- The Governor at Elmley should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that they:
    - complete all assessments and relevant paperwork, fully, accurately, and in accordance with the agreed timescales, at all stages of the ACCT process;
    - hold multidisciplinary case reviews with relevant healthcare staff and other keyworkers providing detailed input if they are unable to attend;
    - ensure agreed actions are recorded on the caremap and the ACCT is not closed until all caremap actions have been fully completed; and
    - complete a post-closure interview within seven days of the ACCT being closed.
- The Governor and Head of Reducing Reoffending at Rochester should ensure that there is a clear, written protocol and coordinated oversight of prisoner work placements and that staff record all work-related decisions, warnings and sanctions.
- The Governor at Rochester should ensure that:
    - staff record and share relevant information about a prisoner's wellbeing, along with any information that might affect a prisoner's risk of suicide and self-harm; and
    - the personal officer policy is effective in providing meaningful support to prisoners, and that contacts take place at a frequency in line with the policy.
- The Governor and Head of Healthcare at Rochester should ensure that:
    - a suitably qualified member of healthcare staff is appointed as first medical responder; and
    - staff in the healthcare unit are able to hear medical emergency codes and calls for healthcare assistance over the radio network.
- The Governor at Rochester should ensure that staff adhere to the prison's Substance Misuse Policy when prisoners are found under the influence of an illicit substance, in particular that they call healthcare staff to assess the prisoner and submit an intelligence report.

The Investigation Process

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

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

15. NHS England commissioned a clinical reviewer to review Mr Thrumble's clinical care at the prison.

16. They both interviewed nine members of staff at HMP Rochester and the investigator separately interviewed three prisoners. The investigator also interviewed two members of staff at HMP Elmley and a prison area manager. The interviews took place between April and October 2018.

17. We informed HM Coroner for Kent and Medway of the investigation. The coroner sent us the results of the post-mortem examination. We have given the coroner a copy of this report.

18. One of the Ombudsman's family liaison officers contacted Mr Thrumble's next of kin to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. Mr Thrumble's next of kin wanted to know if Mr Thrumble had a mental health assessment, whether there had been other incidents of self-harm, and what led to him being placed in the segregation unit.

19. We shared our initial report with Mr Thrumble's next of kin. They did not raise any factual inaccuracies.

20. We shared our initial report with the Prison Service. They did not raise any factual inaccuracies. The action plan has been annexed to this report.

Background Information

HMP Rochester

21. HMP & YOI Rochester is a category C resettlement prison. It holds up to 695 adult and young male offenders on seven residential units and it has a separate segregation unit. Oxleas NHS Trust provides health care services at the prison.

HMP Elmley

22. HMP Elmley is a category B local prison serving all Kent courts and housing remand and sentenced adults and young offenders. It has an operational capacity of 1252 prisoners. Integrated Care 24 provide primary care services and Oxleas NHS Trust provides mental health in-reach services.

HM Inspectorate of Prisons

HMP Rochester

23. The most recent inspection of HMP Rochester by HM Inspectorate of Prisons (HMIP) was in October and November 2017. Despite the uncertainties around the future of the prison, inspectors found that progress had been made in key areas since their last inspection. They found an improved level of staff-prisoner relationships, with most prisoners feeling safe and vulnerable men being well-supported. Although the availability of illicit drugs remained a problem, they felt that staff seemed more focused on tackling the issue. Inspectors said that cell conditions were unacceptable and there was a lack of purposeful activity due to restricted regimes caused by staff shortages.

HMP Elmley

24. The most recent inspection of HMP Elmley was in April and May 2019. Inspectors found that there had been some improvements since their last inspection in 2015, including the reception and induction process for prisoners and the care of prisoners at risk of suicide and self-harm. However, inspectors noted that the prison remained 'not sufficiently good' in the four healthy prison areas - safety, respect, purposeful activity and rehabilitation and release planning. Inspectors noted that the number of self-harm incidents had increased but prisoners managed under suicide and self-harm procedures (known as ACCT) were positive about the care they received. Inspectors found some gaps in recording of information and multidisciplinary attendance at ACCT reviews, but noted that a new ACCT quality assurance process had been put in place by the prison.

Independent Monitoring Board

25. 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.

HMP Rochester

26. In its annual report, for the year ending 31 March 2018, the Board described the year as a challenging one with a lot of disruption. The Board considered that the prison had remained stable and performed its role as a resettlement prison as effectively as resources allowed, with prisoners being treated fairly. However, the Board was concerned about the use of illicit drugs, poor cell conditions and a lack of purposeful activity for prisoners.

HMP Elmley

27. In its annual report for the year ending 31 October 2018, the Board reported that there had been a major effort to reduce the import of drugs and tobacco into the prison, and that security was adapting effectively to the ever-changing threat from the criminal community outside. The Board noted that incidents of violence had fallen in the reporting year.

Previous deaths

HMP Rochester

28. Mr Thrumble was the third prisoner to die at Rochester since May 2015. Of the previous deaths, one was self-inflicted and one was drug-related. In previous investigations, we identified deficiencies in the emergency response.

HMP Elmley

29. There were two self-inflicted deaths at Elmley since May 2015. In one of the previous deaths, we made a recommendation about the management of ACCT procedures.

Assessment, Care in Custody and Teamwork

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

31. 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.

32. 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.

Personal Officers

33. Personal officers should get to know the prisoners they are responsible for, act as a first point of contact for any problems, help with resettlement issues and make regular entries in their records about their progress.

Key Events

HMP Elmley – 2 January to 2 March 2018

34. Mr Lee Thrumble was released on licence from HMP Rochester on 5 September 2017. On 2 January 2018, he was recalled to prison custody and sent to HMP Elmley after being convicted of criminal damage. He was sentenced to 10 weeks in custody.

35. Mr Thrumble arrived at Elmley with a self-harm warning form stating that he had tried to swallow tissues following his arrest and had been on constant suicide watch at the police station and at court. His Person Escort Record (PER – a document that accompanies prisoners between courts, police custody and prisons, which sets out the risks they pose) said that he had tied clothing around his neck and scratched his neck with a knife while in police custody. A nurse carried out Mr Thrumble's reception healthcare screening. Mr Thrumble told the nurse that he had recently tried to kill himself by jumping in front of a car and that he still wanted to die. He said that he had started using crack cocaine in the community and he had an outstanding community mental health assessment appointment. The nurse started suicide and self-harm monitoring (known as ACCT) at 5.10pm and made a referral to the mental health team.

36. On 3 January, a senior social worker carried out Mr Thrumble's mental health assessment. Mr Thrumble told the social worker that he was upset to be recalled to prison with only 16 days left on his licence. He said he had argued with his girlfriend while under the influence of crack cocaine and damaged her car. Mr Thrumble said he had been diagnosed with attention deficit hyperactivity disorder (ADHD) as a child but he had not taken any medication for it for the last 10 years. He said he had a history of using cannabis and that, more recently, he had been using crack cocaine. He reported anxiety, depression, poor sleep, paranoia, tearfulness, worry and frustration. Mr Thrumble said he had a history of self-harm but had no current thoughts of suicide or self-harm. He said he was not on any medication but felt he needed help. The social worker added Mr Thrumble to her caseload for social work intervention and support and made a referral for him to see the doctor about his anxiety, depression and difficulties sleeping.

37. Staff held the ACCT assessment interview at 5.20pm on 4 January, 48 hours after a nurse opened the ACCT. This is outside the 24-hour time limit and the reason for this delay was not documented. Mr Thrumble said that he was suffering from anxiety and depression and his medication had not been sorted out. He said he had been using illicit drugs and that he was feeling stressed at the time of his arrest. He said that he had made superficial cuts to his neck and head when he was getting arrested but he said it was not a suicide attempt. Staff held the first ACCT review directly after the assessment interview. They did not identify any caremap actions at the review.

38. Subsequent ACCT reviews took place on 10, 15, 21 and 28 January and 1, 9 and 13 February. On 10 January, staff added a referral to the mental health team as a caremap action. On 15 January, staff identified that Mr Thrumble still had not seen a doctor and added this as a further caremap action. Healthcare staff did not attend or provide input into any of the reviews, despite Mr Thrumble

specifically asking for the mental health team to attend after his review on 15 January.

39. On 15 January, Mr Thrumble started Stepping Stones, a substance misuse group, which he was expected to attend for four weeks.

40. On 16 January, the senior social worker met with Mr Thrumble again. She noted in Mr Thrumble's medical record that his presentation had improved and he appeared hopeful for the future. She noted that he was still waiting for an appointment with the doctor and he was on a waiting list to attend the mental health workshops. He told her that he still had difficulties sleeping. She referred him for one-to-one psychological therapy to address his emotional and relationship difficulties. She noted that she considered Mr Thrumble's risk of suicide and self-harm was low.

41. On 17 January, an assistant psychologist wrote in Mr Thrumble's medical notes that she had discussed Mr Thrumble's case at a team meeting and it was agreed that he should be seen for a psychological assessment as soon as possible.

42. On 18 January, Mr Thrumble left the Stepping Stones group early, saying that the session was bringing up bad memories for him. He did not attend the session the next day and on 23 January, he asked to be removed from the group. There is no indication that anything further was done to support Mr Thrumble in relation to his substance misuse or the psychological impact that the group may have had on him.

43. On 2 February, Mr Thrumble failed to attend an appointment with the triage nurse which would have led to him seeing the doctor about his anxiety and depression, following the senior social worker referral on 3 January. It is not clear from Mr Thrumble's medical record if he knew that this appointment had been scheduled and there is no evidence to show the appointment was rearranged or followed up.

44. On 8 February, the senior social worker met with Mr Thrumble. She wrote in his medical notes that consideration should be given to inpatient admission if Mr Thrumble's mental health should deteriorate. She noted that she would support him to engage with groups and provide him with information on community services on his release. This was the last meeting Mr Thrumble had with her. She told the investigator that she tried to see Mr Thrumble again on 13 February but he was working in the gardens. She said she then went on a period of sick leave and he had been transferred to HMP Rochester by the time she returned.

45. On 12 February, Mr Thrumble attended a coping skills workshop. During the break, the assistant psychologist, spoke to Mr Thrumble as his psychometric scores indicated that he was having suicidal thoughts. Mr Thrumble said that he sometimes had suicidal thoughts but he did not have any plans to end his life. Mr Thrumble attended a mood management group on 14 February but there is no record of him attending any further mental health group sessions at Elmley.

46. On 20 February, staff closed the ACCT. Mr Thrumble was still waiting to see the doctor about his anxiety, depression and sleeplessness (a caremap action from his ACCT review on 15 January) but said he was feeling well-supported and did not need to be on an ACCT. The senior social worker was on sick leave at the

time, and no one from the mental health team attended or provided any input to the ACCT review. An ACCT post-closure interview was scheduled for 27 February but did not take place. Mr Thrumble did not see a doctor about his anxiety and depression before he left Elmley.

47. On 2 March, Mr Thrumble was moved to HMP Rochester. A nurse at Elmley, noted on his medical record he appeared well and he was medically fit for a prison transfer. She wrote that Mr Thrumble had no outstanding hospital or doctor appointments but he was on a waiting list for psychology group work as well as the asthma clinic, dentist and hepatitis B clinic. The mental health in-reach team manager at Elmley, told the investigator that a psychologist from Elmley contacted Rochester's psychology team to let them know that Mr Thrumble was awaiting a psychological assessment for one-to-one work. However, it appears this was not done until 3 April.

HMP Rochester – 2 March to 17 April 2018

48. When he arrived at Rochester on 2 March, Mr Thrumble saw a reception officer who noted that his PER said he had a history of depression, previous suicide attempts and violence. He did not have a reception health screening that day and was placed on D Wing, rather than the first night centre.

49. On 4 March, a nurse carried out Mr Thrumble's reception health screening. This should have taken place within 24 hours of Mr Thrumble arriving and, as he had transferred in from another prison, this should ideally have taken place before he spent his first night at Rochester. The nurse could not say why the screening had been delayed. She said that healthcare staff had tried to arrange the screening on more than one occasion but as Mr Thrumble had been moved to the wing rather than remaining in the first night centre, it had proved difficult to get him to come to the healthcare unit for the screening.

50. The nurse said that she did not review Mr Thrumble's SystmOne record (the electronic medical record) and she did not see the PER or any other documentation while she was carrying out her assessment. She said that she based her assessment on the answers Mr Thrumble gave her to specific questions and she did not have time to review any other records. She said that Mr Thrumble told her he had no thoughts of suicide or self-harm, no substance misuse issues, and she had no concerns about him. She said that she knew how to start ACCT monitoring if she had any concerns about a prisoner, although she said she had never received any formal ACCT or mental health training.

51. On 14 March, Mr Thrumble complained about the Floplast work he was doing (assembling plumbing pipes), saying he could not handle it. Staff gave him a warning and returned him to the wing.

52. On 16 March, Mr Thrumble met with his offender supervisor to discuss his offence and the programmes he could attend. She noted she had no current concerns about substance misuse. Mr Thrumble told her that he had a social worker from the mental health team (he was referring to the senior social worker at Elmley) and that he did not have a diagnosed mental health condition. She said she did not talk about this in depth with him as it was their first meeting and she wanted to build up some trust with him. She said that she was aware Mr

Thrumble had previously been assessed as at high risk of suicide or self-harm when he was first recalled to custody, but she felt this risk had been reduced as he had been on an ACCT at Elmley and she could see no obvious signs that he was at risk. His offender supervisor, said that if she had concerns about Mr Thrumble's mental health, she would have made a referral to the mental health team. She arranged to see Mr Thrumble again the next month.

53. Mr Thrumble missed work at Floplast due to sickness on 20, 22 and 23 March.

54. On or around 26 March, Mr Thrumble received a letter from the Parole Board which said that, as he had breached the conditions of his licence, he would remain in prison until the end of his original sentence which was 15 February 2019. His offender supervisor told the investigator that she could not remember if she had seen the letter. She said that a member of administrative staff would have sent the letter to Mr Thrumble and passed her a copy. She would then have discussed it with him next time she met with him. (His offender supervisor, did not meet with Mr Thrumble again before he died so never discussed the letter with him.) Mr Thrumble's personal officer said she was unaware that Mr Thrumble had received this information and it is not documented on his prison record.

55. On 27 March, Mr Thrumble was suspected of being under the influence of illicit drugs and was unable to attend work. Staff gave him a warning for failing to attend work. On 28 March, he received a further warning for using a vape in the toilets. Staff removed him from the worklist for Floplast and suspended his gym sessions until he could show that he would attend work regularly.

56. Around 29 March, Mr Thrumble started work on D Wing servery. The exact date that Mr Thrumble started work on the servery is not recorded and there is limited information about his progress while working there, other than a positive entry made on 31 March about the high standard of his work. The Head of Reducing Reoffending, said that servery work is usually reserved for prisoners who have shown a good work ethic and have attended the other placements, such as Floplast and the Ministry of Defence (MOD) workshop making camouflage netting. He said he could not understand how Mr Thrumble had managed to get a job on the servery, given that he had previously received warnings for failing to attend work. However, he said his team would simply make the work placement allocation, as requested, without question.

57. An officer said that she had responsibility for hiring and removing prisoners from jobs on the wing and she was also Mr Thrumble's personal officer. She said that Mr Thrumble had worked on the servery when he had last been in Rochester and he had done a good job, so she wanted to have him back on the servery team. She said that he started off really well but he soon started turning up late and did not seem interested in the job. The officer said she spoke to him many times to find out what was going on and she warned him that she would not be able to keep him on if he did not do the job to a good standard. She said that she eventually made the decision to sack Mr Thrumble from the servery on 9 April. She said he was not happy when she told him this but he said he understood. However, none of the conversations between the officer and Mr Thrumble regarding his work on the servery are noted on his record, nor is the date that he

was sacked from the servery. She did, however, put a note on his record on 16 April to say that she had sacked him from the servery as he had been under the influence of illicit substances and that he seemed different on this sentence. She said she made this entry late because she was busy and had been off duty.

58. On 13 April, Mr Thrumble was placed on basic regime (a restricted level of privileges which includes limited time out of his cell) after receiving further warnings for failing to attend work. A prisoner who was friends with Mr Thrumble, said that Mr Thrumble was upset that he had lost his job on the servery. He said that Mr Thrumble told him he was bored and that no one had explained to him why he had lost his job.

Events of 17 April 2018

59. At around 3pm on 17 April, an officer opened the door to Mr Thrumble's cell after he rang his cell bell. Mr Thrumble pushed past her and disobeyed a direct order to return to his cell. She said that she tried to speak to Mr Thrumble to find out what was wrong with him. He said he was upset because he had lost his job on the servery and he was on basic regime. He continued to refuse to return to his cell and, when his personal officer tried to explain to him about why he had lost his job, he became aggressive towards her. Another officer intervened and Mr Thrumble was restrained and escorted to the segregation unit by prison officers and a healthcare assistant. The healthcare assistant said that Mr Thrumble was semi-compliant during the restraint and she noted that he had no injuries.

60. Once in the segregation unit, Mr Thrumble was calmer. The healthcare assistant checked him and he told her he was fine. She did not ask him if he had any thoughts of suicide or self-harm but she said that, based on his presentation, she was not concerned about him. She was not qualified to carry out the segregation algorithm (a healthcare document that assesses the prisoner's suitability for segregation and any potential risks) but she said she expected her colleague; a nurse would do this when administering medication at around 5pm.

61. At around 4pm, an officer observed Mr Thrumble sitting on the table in his cell. Around 20 minutes later, when staff went to Mr Thrumble's cell to take him his dinner, they found the observation panel had been covered and he did not respond to them knocking the door. Staff went into the cell and saw that Mr Thrumble had tied a ligature around his neck and attached it to the leg of his bed. The officer immediately cut the ligature and staff started cardiopulmonary resuscitation (CPR). A custodial manager (CM) called an emergency code blue at around 4.23pm.

62. The healthcare assistant and a nurse were preparing for evening medication when they heard the code blue. The healthcare assistant said that she left immediately with the oxygen and the nurse stayed to lock up the medication. The healthcare assistant arrived at the segregation unit shortly afterwards and saw that prison staff were carrying out CPR. She used her radio to call for urgent healthcare assistance and emergency equipment. Another nurse was in the healthcare unit but he did not hear the code blue or the healthcare assistant's call for assistance. He said that a CM came to the unit to let him know there was a medical emergency, so he made his way to the segregation unit. Both nurses arrived together around 4.29pm with the emergency bag and took charge of the

resuscitation until paramedics arrived at 4.39pm. Ambulance staff resuscitated Mr Thrumble and took him to hospital where he died the following afternoon at approximately 12.05pm.

Contact with Mr Thrumble's family

63. The prison's family liaison officer (FLO), accompanied by the deputy family liaison officer, and the acting deputy governor, met with Mr Thrumble's next of kin at hospital on the morning of 18 April, shortly after Mr Thrumble was pronounced dead. The prison contributed to the cost of Mr Thrumble's funeral, in line with Prison Service instructions.

Support for prisoners and staff

64. The acting governor held a debrief with staff but most of the staff directly involved in the emergency response did not attend. However, staff said that they were offered support by the prison's care team and felt supported by managers and other colleagues.

65. The acting governor posted a notice for prisoners informing them of Mr Thrumble's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Thrumble's death.

Post-mortem report

66. The post-mortem examination found that Mr Thrumble died from hypoxic brain injury (lack of oxygen to the brain), pneumonia and cardiac arrest, caused by partial suspension. Toxicology tests showed that Mr Thrumble had taken psychoactive substances (PS) before he died.

Findings

Transfer and reception

67. Mr Thrumble had been under constant watch by the police when he arrived at HMP Elmley on 2 January. Staff at Elmley monitored him under ACCT procedures until 20 February. He was moved to Rochester just over one week later, on 2 March. We consider that Mr Thrumble's risk of suicide and self-harm was not set out fully when he was moved from Elmley to Rochester. The Person Escort Record (PER) that accompanied him noted that he had depression and had attempted suicide in the past, but gave no detail.

68. Prison Service Order (PSO) 1025: *Communicating Information About Risks on Escort or Transfer*, sets out when the suicide and self-harm section of the PER should be completed, which includes when the prisoner, "*Has recently been, at risk of self-harm (e.g. post closure phase of ACCT plan, PNC suicide/self-harm warning marker in the last six months)*". Mr Thrumble did have a suicide and self-harm warning marker in the last six months. We also consider he was in the post-closure phase of his ACCT as he had not had his post-closure interview that was scheduled for 27 February. We consider the suicide and self-harm section of the PER should have been completed and as it did not, it failed to adequately reflect Mr Thrumble's level of risk.

69. Prison Service Order (PSO) 3050: "Continuity of Healthcare for Prisoners", makes it clear that when prisoners are transferred between prisons, staff must ensure that healthcare needs are assessed and that prisoners receive continuity of care. It says:

    "Written and observed guidelines are in place setting out the procedures for reception, transfer and release that include:

    The identification of physical and mental health problems, indicators of recent substance misuse and the potential for self-harm.

    Ensuring information on continuing care is conveyed to other establishments on transfer……"

70. Just before Mr Thrumble was moved to Rochester, a nurse at Elmley noted that he had no outstanding healthcare appointments but he was on a waiting list for psychological group work. This was incorrect as he was in fact waiting to see the doctor in relation to anxiety, depression and difficulties sleeping (an outstanding action from his ACCT caremap), and awaiting a psychological assessment. Despite Mr Thrumble being on the senior social worker's caseload at Elmley, no details of this engagement were passed to Rochester.

71. The mental health in-reach manager at Elmley, said that a handover report should have been completed but he could not say why this did not happen. We make the following recommendation:

    The Governor and Head of Healthcare at Elmley should ensure that for prisoners transferring to another prison, staff should:

- **set out all relevant information about the prisoner's risk of suicide and self-harm in the PER, including recent ACCT closure, in accordance with the guidance contained in PSO 1025; and**

- **pass on relevant information about the prisoner to the receiving prison, especially for those with mental health issues who may be at risk of suicide and self-harm.**

72. PSO 3050 says that, due to the increased risk of suicide and self-harm following the stresses of a transfer, prisoners should be seen by healthcare staff before spending their first night in the new establishment. Mr Thrumble's healthcare reception screening did not take place until 48 hours after his arrival at Rochester, by which time he was on D Wing. Prison staff told us that prisoners are often moved onto the wing before they have completed their induction which can cause problems with getting them to important appointments, as was the case for Mr Thrumble's initial health screening. We consider this has the potential for significant risk issues to be overlooked.

73. The reception nurse said that she did not see Mr Thrumble's PER or any other documentation about his risk and she did not have the time to review his SystmOne record. She therefore did not see the information that staff at Elmley had recorded in Mr Thrumble's SystmOne record about his substance misuse, history of self-harm, and mental health needs. Some of the answers Mr Thrumble gave to the nurse's questions were not consistent with the information in SystmOne, but she did not challenge this because she based her assessment on his presentation and what he said to her. She said that she had not had any formal training on suicide or self-harm but she did not think Mr Thrumble was at risk. Mr Thrumble was not offered a secondary healthcare screening which may have identified some of the issues that were missed on the first screening. We make the following recommendation:

The Governor and Head of Healthcare at Rochester should ensure that reception staff are aware of the guidance in PSO 3050 and that newly arrived prisoners are managed in accordance with PSI 07/2015: *Early Days in Custody*, in particular that:

- **reception staff examine all available documentation on the prisoner and consider and record all known risk factors for suicide and self-harm;**

- **reception staff are appropriately trained on the ACCT process and how to spot signs of risk of suicide and self-harm; and**

- **prisoners are not moved onto a general residential wing until they have had an initial healthcare screening, other than for exceptional operational reasons which must be clearly documented; and**

- **every prisoner is offered a general health assessment in the week following first reception.**

Management of ACCT procedures at Elmley

74. Staff at Elmley failed to manage the ACCT procedures in accordance with Prison Service Instruction (PSI) 64/2011: *Managing prisoners at risk of harm to self, to others and from others (Safer Custody)*. In particular, the ACCT assessment interview was delayed by 24 hours, the ACCT reviews were not multidisciplinary (even when Mr Thrumble specifically requested input from the mental health team), the ACCT was closed before caremap actions had been completed (Mr Thrumble was still waiting to see the doctor), and no post-closure interview was held.

75. As a result, Mr Thrumble's mental health needs were not appropriately addressed and significant risk information about his mental health was not shared with relevant people. We make the following recommendation:

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

    - **complete all assessments and relevant paperwork, fully, accurately, and in accordance with the agreed timescales, at all stages of the ACCT process;**
    - **hold multidisciplinary case reviews with relevant healthcare staff and other keyworkers providing detailed input if they are unable to attend;**
    - **ensure agreed actions are recorded on the caremap and the ACCT is not closed until all caremap actions have been fully completed; and**
    - **complete a post-closure interview within seven days of the ACCT being closed.**

Information sharing and record keeping

76. There was confusion about what Mr Thrumble should have been doing in relation to work and purposeful activity. At times it appeared he was suspended from work, yet he was sanctioned for non-attendance. We were told by The Head of Reducing Reoffending, that Mr Thrumble should only have been required to work on one placement at a time, yet records showed that he was assigned to more than one placement. We consider this would have been a source of frustration for Mr Thrumble. An officer failed to record details of her conversations with Mr Thrumble when he allegedly attended late for his job on the servery. Furthermore, she did not accurately record the reasons for sacking him from the servery and she delayed in making this entry in his prison record. We make the following recommendation:

    The Governor and Head of Reducing Reoffending at Rochester should ensure that there is a clear, written protocol and coordinated oversight of prisoner work placements and that staff record all work-related decisions, warnings and sanctions.

77. We found there were missed opportunities to share and act on information that may have helped to identify Mr Thrumble's risk and to offer him appropriate support. Staff who knew him from previous sentences, including his personal officer, noted that his presentation had changed and he was spending a lot of time in his cell, but they did not act on this. Additionally, Mr Thrumble told his offender supervisor, about substance misuse and mental health issues, including the fact that he had a mental health social worker, but she did not share this with healthcare staff or arrange appropriate referrals.

78. Around three weeks before Mr Thrumble died, he received a letter from the Parole Board telling him that he would not be released from prison until the end of his original sentence, in February 2019. His offender supervisor said she would have received a copy of the letter but would not have spoken to him about it until their next meeting. We consider that this would have been disappointing news for Mr Thrumble that could have affected his risk of suicide and self-harm and she should have made staff on the wing aware of it.

79. Also, no one working directly with Mr Thrumble on the wing was aware that he had been downgraded to basic regime. We consider that his personal officer should have had a better understanding of what was going on for Mr Thrumble in order to offer him appropriate support. We make the following recommendation:

The Governor at Rochester should ensure that:

- **staff record and share relevant information about a prisoner's wellbeing, along with any information that might affect their risk of suicide and self-harm; and**

- **the personal officer policy is effective in providing meaningful support to prisoners and that contacts take place at a frequency in line with the policy.**

Emergency response

80. We heard from healthcare staff that there were insufficient qualified nurses on duty on 17 April, so no one was appointed as the first medical responder. Both qualified nurses were carrying out other duties at the time the code blue was called. A nurse was in the process of administering evening medication so she sent the healthcare assistant to the segregation unit with the oxygen while she put away the medication, before following on shortly afterwards. Another nurse did not hear the emergency call due to an intermittent problem with the radio reception in the healthcare unit. He was only alerted to the emergency when a member of prison staff told him.

81. While we found that these issues resulted in a short delay in qualified healthcare staff taking an active role in the resuscitation, we do not consider it would have affected the eventual outcome for Mr Thrumble. We found that prison staff responded promptly and provided a high standard of care in attempting to resuscitate Mr Thrumble while waiting for medical assistance to arrive.

Nevertheless, in order to reduce the potential for delays in future medical emergencies, we make the following recommendation:

The Governor and Head of Healthcare at Rochester should ensure that:

- **a suitably qualified member of healthcare staff is appointed as first medical responder; and**
- **staff in the healthcare unit are able to hear medical emergency codes and calls for healthcare assistance over the radio network.**

Substance misuse

82. We found that staff did not adhere to their own substance misuse policy when Mr Thrumble was suspected of being under the influence of illicit substances. Although this information was recorded in his prison record, they did not inform healthcare or submit security intelligence reports. We make the following recommendation:

The Governor at Rochester should ensure that staff adhere to the prison's Substance Misuse Policy when prisoners are found under the influence of an illicit substance, in particular that they call healthcare staff to assess the prisoner and submit an intelligence report.

Use of force

83. Prior to Mr Thrumble being restrained, we are satisfied that staff made efforts to defuse the situation. We consider that the use of force was necessary and proportionate.

Prisons & Probation
Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

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

T I 020 7633 4100
F I 020 7633 4141