Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christian Hinkley, a prisoner at HMP Swaleside, on 29 July 2019

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*

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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 Christian Hinkley died on 29 July 2019 after setting fire to his cell at HMP Swaleside. He was 33 years old. I offer my condolences to Mr Hinkley's family and friends.

Mr Hinkley had a history of substance misuse and self-harming. He was on a drug detoxification programme throughout his time at Swaleside. He had a diagnosis of attention deficit hyperactivity disorder (ADHD) and emotionally unstable personality disorder (EUPD). He also suffered from back pain for which he had been prescribed pregabalin since 2012.

Mr Hinkley was supported by appropriate services, including the pain clinic, and had regular medication reviews. He frequently told staff that he needed to remain on pregabalin as it helped with his anxiety and he threatened to self-harm if it was stopped. Mr Hinkley was monitored under suicide and self-harm prevention procedures (known as ACCT) five times at Swaleside and was admitted to the healthcare inpatient unit on one occasion due to substance misuse and mental health issues.

In June 2019, when Mr Hinkley began using illicit substances and attempting to divert his medication to other prisoners, healthcare staff stopped his pregabalin. On 1 July, Mr Hinkley made a deep cut to his leg, refused all medication and medical intervention and his mental health deteriorated. Although staff were concerned and referred him to the mental health team, no one considered starting ACCT monitoring.

The investigation found failings in identifying Mr Hinkley's risk of suicide and self-harm and the management of the ACCT process. The investigation also found failings with the roll check that took place shortly before Mr Hinkley set fire to his cell, the emergency response, and healthcare record keeping.

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 **July 2020**

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Summary

Events

1. On 11 April 2017, Mr Christian Hinkley was sentenced to 14 years imprisonment for grievous bodily harm against his partner. He was moved to HMP Swaleside on 22 May.

2. Mr Hinkley had attention deficit hyperactivity disorder (ADHD) and emotionally unstable personality disorder (EUPD) and a history of self-harm. He also had a history of substance misuse and was prescribed methadone (opiate substitute) as part of a drug detoxification programme. Mr Hinkley engaged with substance misuse and mental health services in prison.

3. Mr Hinkley was prescribed pregabalin, a pain killer, for a back injury sustained in 2012 and had regular reviews with the pain management clinic. Pregabalin is a controlled drug and highly tradeable in a prison setting, so healthcare staff told him he would need to reduce and eventually stop this medication. Mr Hinkley was unhappy about this and made threats to harm himself if he could not continue to have pregabalin. He said pregabalin helped him with his anxiety and did not want to consider other options.

4. Mr Hinkley had regular medication reviews and changes were made to his ADHD medication and his methadone detoxification dosages. He had a period of settled and positive behaviour between June and August 2018. However, his behaviour began to deteriorate and he spent a long time on the basic regime from December 2018 after he admitted to using illicit drugs and making “hooch” (illicit alcohol).

5. Mr Hinkley was an inpatient in the prison’s healthcare unit between 10 May and 5 June 2019 after he stopped taking his medication and staff were worried about a decline in his mental health.

6. Staff started ACCT monitoring on 21 June after Mr Hinkley self-harmed by cutting himself. Staff stopped ACCT monitoring the following day. Mr Hinkley’s family contacted the prison on 25 June to say they were concerned about his wellbeing and staff restarted ACCT monitoring on 28 June. (Mr Hinkley had been monitored under ACCT procedures on four separate occasions prior to 21 June 2019 - 4 to 13 September 2018;17 to18 January 2019; 28 March to 23 April 2019; and 12 to16 May 2019.)

7. On 1 July, Mr Hinkley made a deep cut to his leg and refused to be seen by healthcare staff. He said he was protesting because his pregabalin was being stopped. On 9 July, staff stopped ACCT monitoring. Staff were concerned about a decline in his mental health and referred him to the mental health team. On 26 July, a nurse placed him on the waiting list for a mental health assessment.

8. On 28 July, at around 11.30pm, Mr Hinkley barricaded himself in his cell and set it on fire using electric wires from his kettle. Staff tried to put out the fire through the inundation port on the door, but the barricade was stopping the water from getting to the fire. They opened the door using an anti-barricade tool, but the flames were too hot and they could not go in. The fire service arrived and put the

flames out once staff opened the door again. The fire officers and staff brought Mr Hinkley out of the cell and started cardiopulmonary resuscitation (CPR). An ambulance was called at midnight and paramedics reached Mr Hinkley at 12.36am. Paramedics took over CPR but they were unable to resuscitate Mr Hinkley and pronounced him dead at approximately 1.15am.

Findings

9. We found that staff failed to adequately manage Mr Hinkley's risk of suicide and self-harm in the weeks before his death. When Mr Hinkley cut himself on 1 July, he was being monitored under ACCT procedures but no one held an ACCT review until eight days later, when a decision was made to stop ACCT monitoring. Although staff remained concerned about a decline in Mr Hinkley's mental health, no one considered restarting ACCT procedures after 9 July.

10. We found failings in the management of ACCT procedures and, in particular, the period of ACCT monitoring between 21 June and 9 July 2019. Given that Mr Hinkley had recently been a mental health inpatient and was displaying several risk factors, we consider that staff stopped ACCT monitoring prematurely after only one day on 22 June (although staff restarted them on 28 June). We also found that ACCT procedures were not carried out in accordance with national guidance, in that case reviews were not multidisciplinary, healthcare staff did not attend the first case reviews, and caremaps were not completed appropriately.

11. The operational support grade (OSG) who checked on Mr Hinkley around 8.00pm on 28 July, was unable to see into his cell because he had blocked the observation panel. The OSG said he got a verbal response but he did not ask Mr Hinkley to remove the obstruction. We found this to be against local protocol for conducting a roll check.

12. We found that staff do not routinely call an ambulance when a prisoner sets fire to a cell. Although an ambulance was eventually called just before midnight, Mr Hinkley had been in the cell for about 30 minutes by this time. The ambulance was delayed and paramedics took approximately 38 minutes to reach Mr Hinkley. We are satisfied that healthcare staff, prison staff and fire service staff carried out CPR to a good standard and we do not know if the presence of paramedics at an earlier stage would have altered the outcome for Mr Hinkley. However, we know that in an emergency situation, a delay of a few minutes may be crucial and we consider that an ambulance should be requested at the earliest opportunity, particularly when a prisoner cannot be removed from the cell quickly.

13. The clinical reviewer found that the standard of healthcare given to Mr Hinkley was equivalent to that which he would have expected to receive in the community. However, she had some concerns about the standard of healthcare record keeping.

Recommendations

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that staff:
    - assess the level of risk based on all available information and known risk factors and not solely on a prisoner's presentation, and record the reasons for the decision;
    - hold multidisciplinary ACCT reviews, with healthcare staff in attendance at first case reviews;
    - set effective caremap actions that are specific and meaningful, update them at each case review, and do not close the ACCT until all caremap actions have been completed; and
    - complete the relevant paperwork, fully and accurately, at all stages of the ACCT process.
- The Governor and Head of Healthcare should ensure that staff consider starting ACCT procedures whenever they are concerned about a prisoner's risk of suicide or self-harm and that they clearly document their decision-making.
- The Governor should ensure that staff conduct roll checks in accordance with local policy, including that they:
    - complete a visual check of the prisoner to ensure they are safe and well; and
    - ask prisoners to uncover their observation panels so that they can see them.
- The Governor should arrange for this report to be shared with the OSG and for a senior manager to discuss our findings with him.
- The Head of Fire Safety at HMPPS should review PSI 11/2015 and incorporate guidance to staff on considering the need to call an ambulance in the event of a fire.
- The Governor should ensure that the prison defibrillators are regularly maintained so that they are always in good working order.
- The Head of Healthcare should ensure that registered clinical staff are trained in intermediate life support, especially those who may be the only medical responder in the establishment.
- The Head of Healthcare should ensure that:
    - all relevant staff should have access to SystmOne following a death so that they can document all actions taken during an emergency incident; and
    - the record keeping of clinical staff is accurate and precise at all times and in line with their regulatory body guidance.

The Investigation Process

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

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

16. NHS England commissioned an independent clinical reviewer to review Mr Hinkley's clinical care at the prison.

17. They jointly interviewed nine members of staff at Swaleside. The interviews took place in October 2019.

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

19. We contacted Mr Hinkley's parents to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Hinkley's next of kin appointed a solicitor to act on her behalf but did not raise any specific questions. Mr Hinkley's other next of kin appointed a solicitor to act on his behalf and asked the following:

    - Was any action taken by the prison when the family raised concerns about Mr Hinkley's behaviour?
    - Was Mr Hinkley's mental health, substance misuse and self-harming behaviour being monitored by the prison?
    - How was Mr Hinkley able to start a fire in his cell and what items did he use to barricade the door?
    - Are there smoke detectors or sprinklers in the prison and were they active?
    - Did staff try to extinguish the fire?

    These issues are addressed in our report.

20. We shared our initial report with the solicitor representing Mr Hinkley's family. The solicitor raised some issues which did not affect the factual accuracy of the report and these have been addressed in separate correspondence.

21. We shared our initial report with the Prison Service. The Prison service identified factual inaccuracies which has resulted in some changes to this report. The action plan has been annexed to this report.

Background Information

HMP Swaleside

22. HMP Swaleside, on the Isle of Sheppey, is part of the Long-Term and High Security estate. It houses up to 1,112 men serving sentences of four years or more. Integrated Care 24 Ltd provides primary healthcare. There is 24-hour nursing cover and a 17-bed inpatient unit. Minster Medical Group provides GP cover on weekdays on Monday to Friday, and Medway on Call Care provides an out of hours GP service. Oxleas NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

23. The most recent inspection of Swaleside was in December 2018. Inspectors found that Swaleside was safer and more respectful than at the previous inspection in 2016, but that progress was very lopsided, with work to help rehabilitate prisoners and reduce individual risk actually getting worse. Violence had risen considerably since the last inspection and reducing violence remained a key task.

24. Inspectors found that levels of self-harm were lower than at comparable prisons, but that there had been five self-inflicted deaths since the last inspection. Work to embed the PPO's recommendations following fatal incident investigations was weak and local policies to reduce self-harm were limited. Self-harm incidents were not investigated and the case management support for many of those in crisis was mixed. Despite this, many prisoners said they felt well cared for and work to help reduce self-harm among prisoners with complex needs was impressive, with some elements constituting good practice.

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. In its latest annual report, for the year to 30 April 2019, the IMB said they felt the general state of the prison was much more settled and calm than the previous year, much more so than statistics may suggest. They still had concerns over the level of violence and noted that debt was the main contributor, which was inextricably linked to the drug culture. They were disappointed that some prisoners chose to remain behind their doors, due mainly to debt incurred through drug trading and said that, if this was not addressed, the situation would worsen.

26. The IMB noted that the apparent easy acquisition of drugs, phones and weapons increased violence, caused problems for other prisoners, multiplied debt problems and caused suicide attempts. The Board said that efforts to reduce the supply of drugs, phones and weapons were appreciated but must continue unabated in order to improve the problem.

Previous deaths at HMP Swaleside

27. Mr Hinkley was the 18th prisoner to die at Swaleside since July 2016. Of the previous deaths, six were self-inflicted, eleven were due to natural causes, and one was drug-related. There have been three further deaths at Swaleside since Mr Hinkley's. Previous investigations into self-inflicted deaths have identified concerns with the management of suicide and self-harm prevention measures, record keeping, roll check procedures and the emergency response.

Assessment, Care in Custody and Teamwork (ACCT)

28. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions on the caremap have been completed.

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

Key Events

30. Mr Christian Hinkley was remanded in prison custody on 4 October 2016, charged with grievous bodily harm against his partner, and sent to HMP Elmley. He had previously been released from Elmley in July 2016.

31. Reception staff identified that he had attention deficit hyperactivity disorder (ADHD), emotionally unstable personality disorder (EUPD), and a history of substance misuse and self-harm. He engaged with mental health and substance misuse services while at Elmley.

32. On 11 April 2017, Mr Hinkley was sentenced to 14 years imprisonment. He was not expecting such a long sentence and said he was going to appeal. He was moved to HMP Swaleside on 22 May 2017.

33. On arrival at Swaleside, reception staff noted no concerns about suicide or self-harm but referred him to the substance misuse and mental health services. Mr Hinkley was appropriately assessed by healthcare. He was prescribed Concerta (for ADHD); Omeprazole (stomach acid medication); pregabalin (pain relief for back pain); quetiapine (antipsychotic); and 35ml methadone (opiate detoxification).

34. On 5 June, a prison GP saw Mr Hinkley for a mental health review. The prison GP advised that he should complete the methadone detoxification programme and engage with psychological support and then re-refer for mental health support if it was still needed.

35. On 12 July, a prison GP carried out a medication review with Mr Hinkley and noticed that his ADHD symptoms were poorly controlled. He increased the dosage of Concerta from 18mg to 36mg. He saw Mr Hinkley again on 27 July and noted a marked improvement in his ADHD symptoms. He recorded that Mr Hinkley was more settled and calmer on the increased dose. Mr Hinkley also reported that he was not anxious as pregabalin was helping him.

36. On 24 January 2018, Mr Hinkley had a review at the pain clinic. The nurse discussed stopping pregabalin as it was no longer needed to control his pain. Mr Hinkley said that pregabalin was helping him with anxiety and he did not want to stop taking it.

37. On 14 March, Mr Hinkley was discharged from the pain clinic and referred to the mental health team to discuss the use of pregabalin for anxiety. Mr Hinkley's medication continued as usual.

38. On 6 June, a prison GP saw Mr Hinkley for a review of his ADHD medication. Mr Hinkley reported a period of settled and positive behaviour. He was getting positive reports from wing staff and had a job. He also reported contact with his family, including a forthcoming visit from his twin daughters who he had not seen in five years. The prison GP noted that Mr Hinkley was continuing to engage with the substance misuse service and was currently receiving 28ml of methadone on a reducing dose. Mr Hinkley requested an increase in his Concerta medication and he agreed to increase it from 36mg to 54mg. He also prescribed a sleeping tablet as Mr Hinkley said he had problems getting to sleep.

39. On 6 July, Mr Hinkley requested an increase in methadone. A substance misuse nurse discussed his request at a multidisciplinary team (MDT) meeting on 19 July and staff agreed to increase it from 28ml to 35ml.

40. A prison GP made attempts to see Mr Hinkley on 9 July and 6 August but each time he was off the wing. He discharged him from his caseload.

41. On 23 August, Mr Hinkley again requested an increase to his methadone prescription. Staff refused as there was no clinical need for an increase. He then told staff that he was using illicit drugs on top of his methadone.

42. On 4 September, staff started ACCT monitoring after Mr Hinkley said people were "against him" and he felt suicidal. Staff held the first case review on 5 September but healthcare staff did not attend. Staff stopped ACCT monitoring on 13 September after Mr Hinkley said he was coping better and his risk had reduced.

43. On 14 September, a prison GP agreed there was no clinical need to increase Mr Hinkley's methadone but suggested a further referral to the mental health team to review his ADHD medication and rule out any physical conditions that might be contributing to his anxiety and behaviour.

44. On 19 September, a psychiatrist assessed Mr Hinkley. The psychiatrist did not increase any of his medication but suggested a referral to psychological therapy. Staff made the referral on 3 October.

45. On 8 October, a prison GP saw Mr Hinkley while he was at the gym. He increased his Concerta medication from 54mg to 108mg. He also stopped his antipsychotic medication and prescribed melatonin to help him sleep. Mr Hinkley expressed concern about reducing pregabalin, saying that it helped his anxiety. The GP said that this would be discussed at an MDT meeting.

46. On 9 October, Mr Hinkley was placed on a waiting list for a mindfulness group with Bradley Therapy Services.

47. On 21 October, Mr Hinkley was found in possession of hooch (illicitly brewed alcohol). He was placed on a disciplinary charge and downgraded to the basic regime. Staff submitted an intelligence report.

48. On 24 October, staff started ACCT procedures after Mr Hinkley threatened to hang himself in his cell and told a nurse that he was injecting heroin. He tested positive for heroin.

49. On 26 October, Mr Hinkley attended an MDT meeting with a prison GP, a nurse and a substance misuse worker. He said he had been making hooch so that he could pay for heroin and he was in debt. He said he was anxious about pregabalin being reduced. Staff agreed to increase his methadone to 50ml.

50. On 7 November, Mr Hinkley told a nurse that he was happy with the increase in methadone and he said he was no longer using illicit drugs.

51. On 14 November, Mr Hinkley told a mental health team leader, that he would end his life if staff stopped his pregabalin. The mental health team leader noted that

he was due to be seen at a pain clinic on 28 November with a view to reducing pregabalin. Mr Hinkley said he was not suicidal but would be if pregabalin was reduced.

52. On 15 November, Mr Hinkley was discharged from the mental health team on the basis that he was to focus on substance misuse and the pain clinic regarding his use of pregabalin. Mr Hinkley was still awaiting the mindfulness group.

53. On 28 November, Mr Hinkley attended an MDT meeting. Staff agreed that melatonin was not helping him, so it was stopped. Mr Hinkley was very anxious and threatening about what he would do if staff reduced or stopped his pregabalin and continued to express concerns about it. Staff agreed to continue with pregabalin but would review it again in three months.

2019

54. On 11 January 2019, Mr Hinkley told a mental health nurse that he was feeling paranoid and hearing things. He said he needed to see someone from the mental health team. The nurse made a referral to the mental health team.

55. On 17 January, Mr Hinkley made cuts to both his legs and refused to be seen by healthcare staff. He said he was protesting at not being moved to another wing. Staff started ACCT monitoring. By the time of the first case review on 18 January, staff had moved Mr Hinkley from G Wing to C Wing. He told staff at the review that he was feeling happier so they stopped ACCT monitoring. Healthcare staff did not attend the review.

56. Mr Hinkley was booked for a mental health assessment on 23 January, but he refused to see anyone other than the mental health team leader. He said he would wait for him to return from leave the following week.

57. The mental health team leader saw Mr Hinkley on 31 January, 14 February and 20 February. He reported no concerns and noted that Mr Hinkley was settled on C Wing. When he saw Mr Hinkley on 1 March, he said he would see him once more with a view to discharging him from the mental health team as he was stable.

58. On 8 March, Mr Hinkley saw the mental health team leader, and told him that he was hearing voices. He said he had not been using any illicit drugs but wanted his medication reviewed.

59. On 20 March, Mr Hinkley had a medication review with a psychiatrist. The psychiatrist recorded that Mr Hinkley reported thoughts of self-harm but said he no intention to act on them. She reported that he displayed agitation and heightened anxiety which he said was due to the stress of appealing his conviction. She did not make any changes to his medication.

60. On 28 March, staff started ACCT monitoring after Mr Hinkley made cuts to his legs. Staff held the first ACCT review on 29 March, but no healthcare staff attended. Staff held a total of five case reviews, of which only two were multidisciplinary.

61. On 6 April, Mr Hinkley was found to be in possession of hooch.

62. On 16 April, the mental health team leader, attended Mr Hinkley's ACCT review. Staff noted that Mr Hinkley had seen the psychiatrist and had a medication review. He said he had no thoughts of self-harm and his risk was assessed as low. Staff decided to stop ACCT monitoring. Mr Hinkley was later found to be concealing his pregabalin medication so he could divert it to other prisoners (either for money or to pay off his debts). Staff met the following day and decided to start reducing pregabalin with a view to stopping it.

63. On 18 April, Mr Hinkley refused to go to G Wing to collect his methadone. He said another prisoner was hypnotising him through his cell wall and placing negative thoughts in his head. He later went to collect his methadone.

64. On 21 April, Mr Hinkley again refused to attend for his methadone. Staff took his medication to his cell. Staff reported that that he appeared to be withdrawing, muttering to himself, his cell was very untidy and he was displaying bizarre behaviour. Staff made a referral to the mental health team.

65. On 22 April, Mr Hinkley started a fight with the prisoner who he believed was hypnotising him. Staff moved Mr Hinkley from C Wing to E Wing.

66. On 23 April, a nurse assessed Mr Hinkley after staff said he looked as though he was going to collapse. His observations were fine, but he told the nurse he had a blood clot in his neck which was travelling to his head. She sent a task to the mental health team and advised him to let staff know if he was feeling unwell again.

67. On 24 April, a prison GP saw Mr Hinkley. He told her he was hearing voices, had been hypnotised by another prisoner which affected his mental health, and he believed that other prisoners were poisoning his food and were talking about him. The GP concluded that his symptoms were caused by illicit substance misuse and EUPD rather than psychotic illness. She made no change to his medication but advised that he should be reviewed by the mental health team the following week.

68. On 25 April, Mr Hinkley told staff that he had used heroin the night before and did not want to take his medication. A nurse and a substance misuse worker reviewed him but he refused to give a urine sample or to have his physical observations taken. Staff were unable to dispense his medication for safety reasons because he was using illicit drugs.

69. On 28 April, Mr Hinkley said that he no longer wanted methadone as he wanted to detox on his own. Substance misuse staff continued to visit him daily to offer support but he said he did not want his medication.

70. On 2 May, the mental health team manager noticed a decline in Mr Hinkley's mental health and self-care. Mr Hinkley told the mental health team manager that he was no longer taking his methadone and did not want to take any medication. The mental health team manager referred Mr Hinkley to the GP for a review and to consider taking him into the healthcare in-patient unit. Mr Hinkley was seen by a prison GP who agreed that he should be admitted for in-patient treatment as soon as a bed became available.

71. On 10 May, Mr Hinkley was admitted to the healthcare in-patient unit.

72. On 12 May, Mr Hinkley broke his television and threatened to use the glass to cut his leg. Staff started ACCT monitoring. They held the first case review on 13 May but it was not attended by healthcare staff. Staff held a total of three case reviews, of which one was multidisciplinary.

73. On 15 May, Mr Hinkley was assessed by, a psychiatrist who concluded that he was not presenting with psychotic illness but that his behaviour was due to substance misuse. She noted that Mr Hinkley was happy with his current ADHD medication and he had now detoxed on his own and wanted to go back to the wing. She recommended discharge from psychiatric inpatient care.

74. Staff stopped ACCT monitoring on 16 May after Mr Hinkley said he was feeling better after seeing the psychiatrist. Staff noted that he had no thoughts of suicide or self-harm and his risk was assessed as low.

75. On 23 May, staff discussed Mr Hinkley at an MDT meeting. The psychiatrist noted that Mr Hinkley had complex needs and his symptoms of ADHD were prominent, despite medication. She noted that there were problems relocating him back to normal location due to issues on various houseblocks. The psychiatrist agreed to review his ADHD medication and discuss a reduction of pregabalin.

76. On 29 May, the psychiatrist saw Mr Hinkley. She noted that his ADHD was not well controlled and discussed a change of medication with him. He agreed to the change. She also discussed the reduction of pregabalin as there was no clinical need for it. Mr Hinkley said he did not want to reduce it and threatened to harm himself or others if she reduced it as he said it helped with his anxiety. She offered to discuss other options for anxiety but Mr Hinkley refused. She noted a plan to reduce pregabalin by 100mg per week for the following six weeks.

77. The psychiatrist saw Mr Hinkley again on 5 June. She noted that he was flooding his cell in protest at having pregabalin reduced. She said that he was verbally threatening, hostile and abusive towards her. She noted no mental illness or significant anxiety although symptoms of ADHD were present and being treated. She agreed to increase the dosage of his new ADHD medication and considered it no longer necessary for him to be an in-patient. Mr Hinkley was discharged with a plan to continue the reduction of pregabalin and engage with the mental health team about his ADHD medication.

78. On 21 June, the mental health team manager saw Mr Hinkley. He told the mental health team manager that he had stopped taking his ADHD medication as it was not helping him. He said he was upset about his pregabalin being stopped and would be appealing the decision.

79. On 21 June, staff started ACCT monitoring after Mr Hinkley made cuts to his arm, chest and leg because the power in his cell had gone off and he could not play his music. A Custodial Manager (CM) chaired the first ACCT review on 22 June but healthcare did not attend. The CM noted that Mr Hinkley presented in a calm manner. She recorded that he looked healthy and well in himself and she had no further concerns about self-harm. At interview, the CM said that she felt she had sufficient knowledge of Mr Hinkley to be able to assess that he was not going to harm himself again. She considered her decision to stop ACCT

monitoring after one day was a reasonable one. However, she said she did not know that he had recently been an inpatient due to his mental health and substance misuse issues.

80. On 25 June, a safer custody officer noted in Mr Hinkley's record that she had checked on him after his family telephoned the prison to say they were concerned about him. Phone records show that Mr Hinkley had made calls to his grandmother and his father where he appeared to be displaying paranoid and delusional behaviour. After checking on him, she noted that he said he was fine but would like a move to B Wing as he did not feel comfortable on E Wing.

81. On 28 June, staff restarted ACCT monitoring although it is not clear from the documentation what prompted this.

82. On 1 July, Mr Hinkley had an ACCT case review but he refused to engage, other than telling staff that he was going to harm himself. Staff scheduled a further ACCT review for 8 July. Later that day (1 July), Mr Hinkley made a deep cut to his leg and refused healthcare intervention. He said he was protesting about his pregabalin being stopped.

83. On 5 July, a mental health team manager saw Mr Hinkley. He said he wanted to move from E Wing and to have his pregabalin reinstated. He said he would continue to refuse all healthcare intervention and medication until this happened. The mental health team manager agreed to discuss his request at the next MDT meeting.

84. On 6 July, Mr Hinkley was moved to B Wing.

85. On 8 July, Mr Hinkley's ACCT review was cancelled due to a lack of staff and re-scheduled to take place the following day. However, a prison GP saw Mr Hinkley for a medication review. Mr Hinkley asked to return to previous ADHD medication (Concerta) and also for pregabalin to be reinstated. He said he had lost his job on the servery because he had moved wings and said he wanted his job back. The prison GP agreed to reinstate his Concerta medication. He concluded that Mr Hinkley showed no evidence of a severe mental disorder and noted that the GP and primary healthcare team could continue with his care.

86. On 9 July, a CM chaired Mr Hinkley's rescheduled ACCT review. The review was also attended by the prison chaplain. The CM noted that Mr Hinkley was happy to be on B Wing and he had not self-harmed for a couple of weeks. Staff did not discuss the cut on Mr Hinkley's leg made on 1 July, for which he continued to refuse treatment. Staff decided to stop ACCT monitoring and a post-closure interview was scheduled for 16 July.

87. On 13 July, the prison chaplain told Mr Hinkley that a close family member was in a hospital intensive care unit. Mr Hinkley said that he did not care about his family member, when he was told the following day that her life support was being switched off, he said he did not want any further information about her.

88. On 16 July, a CM met with Mr Hinkley for his ACCT post-closure interview. Mr Hinkley said he felt happier and safer on B Wing and that he had support from friends, family and the in-reach team. We found no evidence that the CM

discussed Mr Hinkley's ongoing refusal to accept treatment for his leg wound or how he might have been feeling about the recent loss of his family member.

89. Healthcare staff made six further attempts to engage with Mr Hinkley so that they could tend to his leg wound, but he declined each time. On 20 July, a nurse made a referral to the mental health team. A mental health nurse reviewed the referral and noted that healthcare staff considered Mr Hinkley had capacity to refuse treatment. The mental health nurse noted that the referral to the mental health team was inappropriate.

90. Staff continued to be concerned about a deterioration in Mr Hinkley's mental state, so a further referral was made to the mental health team on 25 July.

91. On 26 July, a mental health nurse reviewed the referral and placed Mr Hinkley on the waiting list for a mental health assessment.

Events of 28/29 July

92. On 28 July, an operational support grade (OSG) was carrying out a roll check at around 8.05pm. Mr Hinkley's observation panel was covered but the OSG said he got a verbal acknowledgement from him that he was fine. He could not see him and he did not ask him to remove the cover from the observation panel. Shortly before 9.00pm, Mr Hinkley was playing loud music and the OSG went to his cell to ask him to turn the music down. The OSG said that Mr Hinkley swore at him and he went away. He did not see Mr Hinkley as the observation panel remained covered.

93. At around 11.30pm, a prisoner pressed his cell bell and, as the OSG was on his way to the cell, he could smell smoke and realised there was a fire. The prisoner indicated to him that the smoke was coming from Mr Hinkley's cell. He went to Mr Hinkley's cell and, although the observation panel remained covered with paper, he could see through a gap at the side that there were flames in the cell. He immediately used his radio to alert the control room that there was a fire in the cell and began to get the respiratory protective equipment (RPE) ready.

94. Two officers responded immediately, putting on the RPE equipment and getting the hose to start putting the fire out. The night orderly officer took charge of the incident and directed the officers in trying to put out the fire. Two other officers arrived to assist and a nurse was called to provide healthcare assistance.

95. The officers took turns to inundate the cell with water through the inundation port (a hole in the cell door which can be opened to insert a fire hose) under the direction of the night orderly officer, but they soon realised that Mr Hinkley had barricaded his cell with furniture which was stopping the water from getting to the fire. An officer got an anti-barricade key and opened the door so that staff could attempt to get Mr Hinkley out. However, the flames were too hot so they had to close the door and continue to attempt to put out the fire through the inundation port.

96. Body-worn camera footage shows that the fire service arrived at the prison around 11.52pm. At 12.10am, staff opened the cell door so that the fire service could use their equipment to put the fire out. Fire service staff and officers went into the cell and pulled Mr Hinkley out into the corridor at 12.13am. A nurse

started cardiopulmonary resuscitation (CPR) assisted by officers and fire officers. The nurse tried to use the defibrillator located on B Wing, but it was not working correctly. The fire brigade used their defibrillator to assist with CPR. The footage shows that the night orderly officer requested an ambulance at 11.58pm and the paramedics arrived and took over CPR at 12.36am. They were unable to resuscitate Mr Hinkley and, at approximately 1.15am, they declared that he had died.

Contact with Mr Hinkley's family

97. At 5.45am on 29 July 2019, the prison's family liaison officer (FLO) and a prison manager, attended the home address of Mr Hinkley's mother to tell her that her son had died. The FLO also contacted Mr Hinkley's father by telephone at 8.45am on the same day to inform him of his son's death. The prison contributed to the cost of Mr Hinkley's funeral in line with national guidance.

Support for prisoners and staff

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

99. The prison posted notices informing other prisoners of Mr Hinkley'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 Hinkley's death.

Post-mortem report

100. The post-mortem report concluded that Mr Hinkley died from the effects of carbon monoxide poisoning and smoke inhalation as a result of deliberate self-ignition. Toxicology reports showed the presence of alcohol (ethanol) in his system.

Findings

Management of Mr Hinkley's risk of suicide and self-harm

101. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, gives guidance to staff on how to identify, manage and support prisoners who are at risk of harm to themselves or others. It sets out the procedures (known as ACCT) that must be followed whenever staff assess that a prisoner is at risk of suicide or self-harm. The instruction highlights the need for ACCT reviews to be multidisciplinary and for healthcare staff to attend the first review.

102. Mr Hinkley was managed under ACCT procedures five times at Swaleside. We found that he had a total of 16 ACCT reviews but only five of these reviews were attended by anyone other than prison staff. Additionally, healthcare did not attend any of the first ACCT reviews.

103. The last period of ACCT monitoring in June 2019 started shortly after Mr Hinkley came out of the healthcare inpatient unit but healthcare staff did not attend the first review. A CM said that Mr Hinkley had self-harmed as the electricity had gone off in his cell but, because the electricity had come back on and he presented well, she believed it was reasonable to stop ACCT procedures after only one day. The CM said she did not know about his recent involvement with the mental health team and she accepted that she could have got more information about this if healthcare had been present at the review.

104. While the ACCT was in post-closure, it was opened again on 28 June but the documentation does not clearly state the reason for this. We found that Mr Hinkley's family had contacted the prison to express concerns about his wellbeing but there was also an entry in his record which showed that his electricity had gone off again and he had threatened to harm himself. Whatever the reason, we found that the re-started ACCT was poorly managed, with no input from healthcare and limited effort to engage Mr Hinkley in the process. Mr Hinkley made a deep cut to his leg during this time which he refused to have treated, but this was not mentioned in the ACCT paperwork or considered as a risk factor.

105. The ACCT was closed on 9 July and no caremap was completed. During the post-closure period, Mr Hinkley received news that a close family member was dying. However, this was not discussed with him at the post-closure interview on 16 July and neither was his ongoing refusal to accept treatment for his leg wound.

106. Although both prison and healthcare staff continued to have serious concerns about Mr Hinkley's deteriorating mental health, we found no evidence that anyone considered starting ACCT procedures again. We make the following recommendations:

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

- **assess the level of risk based on all available information and known risk factors and not on a prisoner's presentation, and record the reasons for the decision;**

- **hold multidisciplinary ACCT reviews, with healthcare staff in attendance at first case reviews;**
- **set effective caremap actions that are specific and meaningful, update them at each case review, and do not close the ACCT until all caremap actions have been completed; and**
- **complete the relevant paperwork, fully and accurately, at all stages of the ACCT process.**

The Governor and Head of Healthcare should ensure that staff consider starting ACCT procedures whenever they are concerned about a prisoner's risk of suicide or self-harm and that they clearly document their decision-making.

Roll check

107. When the OSG carried out the evening roll check at around 8.00pm on 28 July, he found Mr Hinkley had covered his observation panel but he did not ask him to remove the obstruction so that he could see into the cell. He also went back to the cell later to ask Mr Hinkley to turn his music down but he still did not look into the cell. We found this was not in accordance with Swaleside's policy on conducting a roll check. Although he received a verbal acknowledgement from Mr Hinkley on both occasions, it is possible that a visual sighting may have provided him with some indication of Mr Hinkley's intentions that evening, although we cannot be sure of this. We make the following recommendation:

The Governor should ensure that staff conduct roll checks in accordance with local policy, including that they:

- **complete a visual check of the prisoner to ensure they are safe and well; and**
- **ask prisoners to uncover their observation panels so that they can see them.**

The Governor should arrange for this report to be shared with the OSG and for a senior manager to discuss our findings with him.

Emergency response

108. PSI 11/2015, *Fire Safety in Prison Establishments*, sets out requirements for prisons to 'have in place a system for effectively managing the risks from fire to which staff and others who may be affected by their undertakings are exposed…'. The PSI requires the prison to 'ensure the implementation of the requirements of this policy via the production of a local fire safety strategy which shall set out the organisation and arrangements for dealing with fire events, and bringing this to the attention of all staff'. The PSI's desired outcomes include 'a reduction in the number of deaths, injuries, associated costs and damage

attributed to fire events in prison'. It states that all confirmed fires must be reported immediately to the local fire service, but it does not require staff to call for an ambulance.

109. We found that staff followed the correct procedures, in accordance with PSI 11/2015, when Mr Hinkley set fire to his cell and that they made brave attempts to rescue him despite the challenges they faced from the barricade and the intense heat. Body-worn camera footage shows that fire alarms were audible throughout the incident and staff regularly checked on the welfare of nearby prisoners as well as trying to get a response from Mr Hinkley.

110. However, we heard from a CM and a nurse that there is no automatic requirement for healthcare to attend when there is a fire and there is no requirement for staff to call for an ambulance. The CM, as the night orderly officer, made decisions on when to request healthcare assistance and when to call an ambulance as the incident progressed. Both the CM and nurse agreed to call an ambulance after Mr Hinkley had been unresponsive in the cell for around 30 minutes. They both said that there was a long delay between Mr Hinkley being brought from his cell and the paramedics arriving.

111. The body-worn camera footage showed there was approximately 38 minutes between the ambulance being requested and the paramedics reaching Mr Hinkley. The reason for this delay is outside of our remit and we do not know if the earlier arrival of the paramedics would have altered the outcome for Mr Hinkley. However, given the serious and unpredictable nature of fires (particularly in the confined area of a prison cell) we are concerned that the PSI does not give guidance about the need to request an ambulance at the same time as the fire service. We therefore make the following recommendation:

The Head of Fire Safety at HMPPS should review PSI 11/2015 and incorporate guidance to staff on considering the need to call an ambulance in the event of a fire.

112. While trying to resuscitate Mr Hinkley, staff found that the defibrillator on B Wing was not working correctly as the pads used to attach the equipment to the patient were out of date. The fire service provided their own defibrillator to assist the resuscitation attempt. While it is unlikely that this affected the eventual outcome for Mr Hinkley, we would expect life-saving equipment to be correctly maintained so that it can be used immediately in a medical emergency. We therefore make the following recommendation:

The Governor should ensure that the prison defibrillators are regularly maintained so that they are always in good working order.

113. A nurse was the first medical responder and said he is often the only nurse in the prison at night. The clinical reviewer was concerned that someone in the role of first medical responder, who is often the only clinician in the prison at night, was only trained in basic life support (BLS) skills rather than intermediate life support (ILS). We make the following recommendation:

The Head of Healthcare should ensure that registered clinical staff are trained in intermediate life support, especially those who may be the only medical responder in the establishment.

Clinical care and record keeping

114. Mr Hinkley made numerous threats to harm himself or others if his pregabalin medication was stopped. Although initially prescribed for back pain, Mr Hinkley said pregabalin helped with his anxiety and he was not prepared to consider other options. We found that healthcare staff allowed Mr Hinkley to continue with pregabalin and delayed reducing it for several months to allow him to adjust to the reduction along with the other changes in his medication. A prison GP suggested a gradual reduction over six to eight months but, when Mr Hinkley began to use illicit drugs and attempted to divert his pregabalin to other prisoners, the multidisciplinary team decided to reduce pregabalin over a shorter period of time due to risk of health deterioration. The clinical reviewer concluded that, in the circumstances, the decision to reduce Mr Hinkley's pregabalin faster than initially agreed was a reasonable one. She considered it was in line with national and local policy.

115. Although the clinical reviewer was satisfied that the nurse responded appropriately to the emergency, she was concerned that his record keeping lacked sufficient detail of his intervention. We make the following recommendation:

The Head of Healthcare should ensure that:

- **all relevant staff should have access to SystmOne following a death so that they can document all actions taken during an emergency incident; and**
- **the record keeping of clinical staff is accurate and precise at all times and in line with their regulatory body guidance.**

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