Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Adam Quelch, a prisoner at HMP Bure, on 25 August 2020

A report by the Prisons and Probation Ombudsman

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Our Vision

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

Our Values

We are:

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

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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 Adam Quelch died of asphyxiation after placing a plastic bag over his head in his cell at HMP Bure on 25 August 2020. He was 23 years old. I offer my condolences to Mr Quelch's family and friends.

Mr Quelch had a significant history of depression and suicidal ideation. In July 2020, he made a serious attempt to take his life by placing a plastic bag over his head and had to be resuscitated, before being transferred to hospital. Prison staff appropriately started suicide and self-harm prevention procedures, known as ACCT, which remained in place until he died.

However, although there was much good practice, I am concerned that staff underestimated Mr Quelch's risk of suicide in the last few weeks of his life by focussing too much on what he said. I consider that, as a result, they inappropriately reduced the frequency of ACCT observations the day before Mr Quelch took his life.

I am also concerned that when Mr Quelch was found with a bag over his head on 25 August, staff did not immediately enter his cell, and that they undertook cardiopulmonary resuscitation while he remained on his bed (which is not good practice). I am also concerned that there was a long delay in getting a defibrillator to his cell. We cannot know if these delays affected the outcome for Mr Quelch.

The clinical reviewer considered that the mental healthcare that Mr Quelch received at Bure was not equivalent to that which he could have expected to receive in the community. Our investigation found that a psychiatrist did not see Mr Quelch for a one-to-one review after he returned from hospital following his attempted suicide in July. This meant that a psychiatrist only saw him during ACCT reviews and did not conduct a full assessment of his mental state or discuss treatment options.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Sue McAllister CB
Prisons and Probation Ombudsman **June 2021**

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Summary

Events

1. In June 2019, Mr Adam Quelch was sentenced to two and a half years in prison for a sexual offence and sent to HMP Pentonville.

2. Mr Quelch had a history of depression and suicidal thoughts. He was managed under Prison Service suicide and self-harm prevention procedures (known as ACCT) at Pentonville after being found with a ligature round his neck and again after taking an overdose of paracetamol.

3. He was referred for a diagnostic assessment for attention deficit hyperactivity disorder (ADHD) but this had not taken place before he transferred to HMP Bure in October.

4. At his initial health screen at Bure, a nurse recorded (incorrectly) that Mr Quelch had not self-harmed in the last 12 months. In November, a mental health nurse reviewed him and concluded that he did not need mental health input.

5. In January 2020, a psychological wellbeing practitioner realised that Mr Quelch had been under the care of the community mental health team and had an outstanding ADHD assessment, and it was therefore agreed that Mr Quelch needed continuing care from the secondary mental health care team. From March 2020 he was prescribed medication for ADHD.

6. On 24 July, an officer found Mr Quelch with a plastic bag over his head and a ligature around his neck. Staff started cardiopulmonary resuscitation (CPR) and established a heartbeat. Paramedics arrived and took Mr Quelch to hospital.

7. On 26 July, Mr Quelch returned to Bure. Prison staff started suicide and self-harm prevention procedures (known as ACCT) and placed Mr Quelch under constant supervision. Staff held nine ACCT reviews over the next two weeks. Mr Quelch's father sometimes attended by phone and a consultant psychiatrist attended on three occasions, which was good practice.

8. On 11 August, staff ended the constant supervision but continued to manage Mr Quelch under ACCT procedures. The frequency of ACCT observations was gradually reduced over the next two weeks.

9. On the night of 23 August, Mr Quelch saw a Listener (a prisoner trained by the Samaritans to support other prisoners) for over one and a half hours. On the morning of 24 August, Mr Quelch's father called the prison and raised concerns about his son's low mood. Later that day, a custodial manager chaired an ACCT review and attendees agreed to reduce Mr Quelch's ACCT observations to one every two hours.

10. Just after midnight on 25 August, an operational support grade looked through Mr Quelch's cell observation panel and saw him lying on his bed with a plastic bag over his face. He radioed a medical emergency code.

11. A custodial manager arrived two minutes later and entered the cell, removed the bag and started CPR. When another officer took over CPR, the custodial

manager left the cell and returned with a defibrillator. Paramedics arrived and took over CPR, but after 30 minutes they pronounced that Mr Quelch had died.

12. The post-mortem report established that Mr Quelch had died of plastic bag asphyxiation. The pathologist concluded that it was possible that death had occurred in part as a result of sertraline toxicity (suggesting that Mr Quelch may have been stockpiling his prescription medication).

Findings

Risk management

13. Mr Quelch had a number of factors which increased his risk of suicide, including a history of depression, previous suicide attempts and recurrent suicidal thoughts that were not easily dismissed.

14. After Mr Quelch made a serious suicide attempt in July 2020, staff appropriately started ACCT procedures and placed him under constant supervision for two weeks. Although the ACCT monitoring continued after that, we found that staff failed to consider Mr Quelch's risk factors fully as part of their ongoing assessment and placed too great a focus on his positive statements. We are particularly concerned that staff misinterpreted Mr Quelch's risk the day before he killed himself and inappropriately reduced his observations.

Emergency response

15. Staff did not immediately enter the cell when Mr Quelch was found with a plastic bag over his head on 25 August. This caused a delay of around one minute. We are also concerned that staff undertook CPR while Mr Quelch was on his bed (which is not good practice) and took 14 minutes to get a defibrillator to his cell.

16. We cannot say if these delays affected the outcome for Mr Quelch.

Clinical care

17. The clinical reviewer considered that the mental healthcare that Mr Quelch received at Bure was not equivalent to that which he could have expected to receive in the community.

18. Healthcare staff missed an opportunity to refer him to the secondary mental health care team shortly after he arrived at Bure, and he was prescribed ADHD medication without a formal specialist assessment.

19. In addition, a psychiatrist did not see Mr Quelch for a one-to-one review after he returned from hospital on 26 July. The clinical reviewer considered that a psychiatrist should have conducted a full assessment of Mr Quelch's mental state and discussed his treatment options.

20. The clinical reviewer also considered that healthcare staff should have reviewed Mr Quelch's sertraline prescription.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:
  - case reviews consider all relevant information that affects risk, and staff only reduce the frequency of observations when there is evidence that the risk has reduced; and
  - conversations are carried out as directed and documented in the ongoing record.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that staff:
  - enter cells as quickly as possible in life-threatening situations;
  - undertake resuscitation on a hard surface, where this is possible without delaying the start of CPR; and
  - take a defibrillator to all medical emergencies.
- The Head of Healthcare should ensure that healthcare staff:
  - review a prisoner's existing medical record as part of the initial screening process; and
  - conduct mental health assessments separately from the ACCT process.
- The Head of Healthcare should ensure that healthcare staff:
  - regularly review prisoners' prescribed antidepressant medication, in line with NICE guidelines;
  - record the reasons for prescribing any medication for an illness that has not been formally diagnosed; and
  - supervise the dispensing of medication closely when a prisoner is being managed under ACCT procedures.
- The Governor should ensure that a copy of this report is shared with the prison manager, CM A, CM B, OSG A, the consultant psychiatrist and the mental health nurse, and that a senior manager discusses the Ombudsman's findings with them.

The Investigation Process

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

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

23. NHS England commissioned a clinical reviewer to review Mr Quelch's clinical care at the prison. The investigator and clinical reviewer interviewed nine members of staff and one prisoner between 19 October and 5 November 2020. All the interviews took place by telephone because of the COVID-19 restrictions.

24. We informed HM Coroner for Norfolk of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent her a copy of this report.

25. One of the Ombudsman's family liaison officers contacted Mr Quelch's father to explain the investigation. Mr Quelch's father asked:

    - whether Mr Quelch's antidepressant medication had been correctly prescribed;
    - why he was only being observed once every two hours;
    - how he had access to a plastic bag; and
    - whether staff took too long to enter his cell?

    We have addressed these concerns in this report.

26. Mr Quelch's father received a copy of the initial report. He raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

    The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Bure

27. HMP Bure is a medium security prison near Norwich which can hold approximately 650 men. Healthcare services are provided by Practice Plus Group, previously known as Care UK, and are available between the hours of 8.00am to 7.00pm.

HM Inspectorate of Prisons

28. The most recent inspection of HMP Bure was in March to April 2017. Inspectors found that Bure was an overwhelmingly safe and respectful prison but that more attention needed to be given to low-level bullying. They also found that although levels of self-harm had reduced since the previous inspection, suicide and self-harm management procedures for prisoners with complex needs were poor.

Independent Monitoring Board

29. 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 31 July 2020, the IMB found that there had been one self-inflicted death and 347 individual cases of self-harm. The Board also noted that levels of violence remained low and that safer custody and chaplaincy staff worked closely with families to help support prisoners.

Previous deaths at HMP Bure

30. Mr Quelch was the fifth prisoner to die at Bure since January 2020. Of the previous deaths, one prisoner took his own life and three died from natural causes. There has since been one death from natural causes.

31. In our investigation into the previous self-inflicted death (which occurred in May 2020), we expressed concern that staff had given too much weight to the prisoner's assertions that he had no thoughts of suicide or self-harm and did not give enough weight to his risk factors and previous patterns of behaviour. We have identified similar issues in this investigation.

Assessment, Care in Custody and Teamwork (ACCT)

32. ACCT is the Prison Service care planning system used to support prisoners at risk of suicide and 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 carried out at irregular intervals to prevent a prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

33. 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. 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.

Key Events

34. On 11 June 2019, Mr Adam Quelch was sentenced to two and a half years in prison for a sexual offence. He was sent to HMP Pentonville. It was his first time in prison.

HMP Pentonville

35. When he arrived at Pentonville, Mr Quelch reported a history of suicidal thoughts, depression and attention deficit hyperactivity disorder (ADHD, a condition that includes symptoms of hyperactivity and impulsiveness). He was prescribed several medications, including sertraline (an antidepressant).

36. At an initial health screen, Mr Quelch told a nurse that he could not guarantee that he would not try to take his own life and she started ACCT procedures.

37. On 29 July, Mr Quelch's cellmate found him with a ligature round his neck. Staff opened ACCT procedures and placed Mr Quelch under constant supervision, which lasted until 8 August. Mental health staff reviewed him frequently and prison staff stopped ACCT procedures on 30 August.

38. On 4 October, Mr Quelch told staff that he had overdosed on paracetamol because he was feeling anxious about his circumstances. Staff started ACCT procedures, which remained in place until 18 October.

HMP Bure

39. On 24 October, Mr Quelch was transferred to HMP Bure. At an initial reception screen, a nurse recorded that Mr Quelch had said that he had not harmed himself in the last 12 months and that he had not recently seen a GP. However, this information was incorrect. A few days later, a Healthcare Assistant (HCA) conducted a secondary health screen and did not identify any concerns.

40. On 10 November, Mr Quelch's keyworker visited him for their first session. She recorded that Mr Quelch said that he had depression and anxiety and that these feelings sometimes resulted in self-harm. Prison staff had a total of 21 keywork sessions with Mr Quelch during his 10 months at Bure. These mostly focussed on ways to improve his behaviour as he frequently failed to adhere to the rules on the wing.

41. On 12 November, a HCA saw Mr Quelch to assess his suitability for the wellbeing service, which provides psychological therapy to prisoners with mild to moderate mental health conditions. However, she had to stop part way through as Mr Quelch became tearful and angry. She recorded that she would ask the mental health team to review him.

42. On 15 November, a mental health nurse reviewed Mr Quelch and noted that he did not report any thoughts of suicide or self-harm and denied any previous community mental health input. Mr Quelch said that he had been diagnosed with ADHD in the past and that he would like some support with anxiety. She concluded that no further mental health input was required and that he could be supported under the care of the wellbeing service.

43. On 27 November, a psychological wellbeing practitioner recorded that Mr Quelch had failed to attend an initial wellbeing service assessment. He contacted wing staff to confirm that Mr Quelch had received an appointment and discharged him from the service.

44. On 4 December, a nurse practitioner reviewed Mr Quelch and he told her that he did not feel that his mental health needs were being met. He said that he felt low and was not sleeping but denied thoughts of suicide or self-harm. She prescribed a short course of zopiclone (sleep medication) and noted that she would request a mental health review. However, there is no record that she did so.

2020

45. On 29 January 2020, a psychological wellbeing practitioner reviewed Mr Quelch's medical record and noted that he had a history of low mood and suicidal ideation and was previously under the care of community mental health services. He also noted that Mr Quelch had been referred for a diagnostic assessment for ADHD at Pentonville but had transferred to Bure before it could take place. He suggested another wellbeing assessment.

46. On 11 February, the secondary care mental health team discussed Mr Quelch's case during a team meeting. They agreed that Mr Quelch needed continuing care from the secondary care team and that they would add him to the caseload of the learning disability nurse.

47. On 19 February, the psychological wellbeing practitioner conducted a wellbeing assessment and recorded that Mr Quelch said that he had had anxiety and low mood for much of his life. He added Mr Quelch to the waiting list for an introductory session on Cognitive Behavioural Therapy (CBT). However, this did not take place due to subsequent COVID-19 restrictions.

48. On 3 March, a consultant psychiatrist reviewed Mr Quelch with the learning disability nurse. He recorded that Mr Quelch had a previous diagnosis of ADHD and suggested that he should trial using atomoxetine (used to treat ADHD).

49. On 31 March, a HCA told Mr Quelch that a member of the mental health team would see him weekly during the COVID-19 restricted regime. Between 8 April and 2 July, a member of the prison's mental health team visited Mr Quelch 13 times, and, on each occasion, he did not report any issues or concerns.

50. On 7 July, a consultant psychiatrist and the learning disability nurse reviewed Mr Quelch. The psychiatrist recorded that Mr Quelch's mental health had stabilised since starting atomoxetine and he discharged him from secondary care.

51. On 22 July, Mr Quelch told a mental health nurse that other prisoners had found out about his offence and assaulted him. He also said that although he spoke to his family every day, he felt that he had no one to speak to. The nurse advised him to write his thoughts down and recorded that he would ask safer custody to issue him with a distraction pack. It is not recorded whether he received one.

Events from 24 July to 20 August

52. At 11.40am on 24 July, an officer unlocked Mr Quelch's cell and found him with a plastic bag over his head and a ligature around his neck. Staff entered the cell after dislodging a barricade that Mr Quelch had put behind the door and started cardiopulmonary resuscitation (CPR). A prison GP attended and established that Mr Quelch had a heartbeat. Paramedics arrived shortly afterwards and took Mr Quelch to hospital. Prison staff began ACCT procedures.

53. On the afternoon of 26 July, Mr Quelch returned to Bure and was located in a constant supervision cell (a cell with a barred gate, instead of a door, designed to enable a prison officer to sit outside and observe a suicidal prisoner constantly). A nurse saw him for a review and recorded that he seemed calm and composed. She told him that he would have to remain in isolation for 14 days in response to the COVID-19 pandemic because he had returned to the prison after being in hospital, and that a member of the mental health team would visit him every day.

54. That evening, a Supervising Officer (SO) conducted an ACCT assessment and recorded that Mr Quelch said he did not remember what had happened or why he would have attempted suicide. She recorded that Mr Quelch was initially tearful and struggled to talk due to an overload of emotions but, after a while, he started to 'open up'. Mr Quelch said that he had had enough of everything and could not cope anymore. He also said that there had been a 'rift on the landing' caused by prisoners finding out about his offence.

55. On 27July, a nurse practitioner prescribed Mr Quelch's medication, which included sertraline. She recorded that due to his recent suicide attempt, he would no longer have his medication in his cell with him and that healthcare staff would administer it daily.

56. That afternoon, a prison manager chaired a first ACCT case review which four members of prison staff, a general nurse and a mental health nurse attended. Mr Quelch's father contributed to the review by telephone. The manager recorded that Mr Quelch presented as withdrawn and failed to respond to most questions. His father encouraged him to explain what had been going on with the other prisoners, but Mr Quelch said it was 'all sorted'. Attendees decided to keep Mr Quelch under constant supervision and added two actions to the caremap: for healthcare to provide something to help him sleep and for Mr Quelch's father to be involved in the ACCT process. Mr Quelch's father later told staff that Mr Quelch had said that the bullying started after he overheard officers talking about his offence.

57. Afterwards, a pharmacist technician administered diazepam (a sedative) to help Mr Quelch sleep.

58. On 28 July, a prison manager chaired an ACCT case review which two members of prison staff, the learning disability nurse and the psychiatrist attended. Mr Quelch's father contributed by telephone. The manager recorded that Mr Quelch was still reluctant to discuss what had been going on with the other prisoners. The learning disability nurse noted that Mr Quelch said he had trust issues with prisoners and staff and that there was a chance he would try to take his life again if he felt low. The psychiatrist said that he would place Mr Quelch under

secondary mental health support. Attendees assessed his risk of suicide as high and kept him under constant supervision.

59. On 29 July, a prison manager chaired an ACCT case review which two members of prison staff and a mental health nurse attended. Mr Quelch's father contributed by telephone. The manager noted that he spoke to Mr Quelch about his trust issues with staff and that, with help from his father, he accepted he would need to communicate more with staff.

60. On 30 July, a prison manager chaired an ACCT case review which two members of prison staff and a nurse attended. Mr Quelch's father contributed by telephone. The manager recorded that Mr Quelch said that he was feeling better but still had thoughts of self-harm. He also noted that Mr Quelch had started to engage more with staff and was making good use of distraction packs. Attendees continued to assess Mr Quelch's risk of suicide as high and decided that he should remain under constant supervision.

61. On 31 July, a Custodial Manager (CM) chaired an ACCT case review in the visits hall, and Mr Quelch's parents attended. He recorded that although Mr Quelch appeared a lot better, he still needed constant supervision.

62. On 3 August, a prison manager chaired an ACCT case review which the learning disability nurse attended. He noted that Mr Quelch said that he had been working on his trust issues with staff and that it had helped to keep himself busy and speak to staff when he felt low. He said that he still had thoughts of self-harm and attendees agreed to keep him under constant supervision.

63. On 6 August, the Head of Safer Custody chaired an ACCT case review which several members of staff attended. Mr Quelch's father contributed by telephone. Mr Quelch said that he was not sleeping well and that he had been reliving the events that led to his attempted suicide. Attendees decided that he should remain under constant supervision until the end of his COVID-19 isolation period at the earliest.

64. On 9 August, a prison manager chaired an ACCT case review which an officer and the learning disability nurse attended. Mr Quelch's father contributed by telephone. Mr Quelch said that he continued to have difficulty sleeping and that he felt worst at night. Attendees decided that Mr Quelch would be given more opportunity to network on the wing, in the hope that this would help him to feel safe and to reintegrate with his peers. He remained under constant supervision.

65. On 11 August, a prison manager chaired an ACCT case review which the psychiatrist and a mental health nurse attended. Mr Quelch's father contributed by telephone. Mr Quelch told attendees that although he had low periods and thoughts of suicide, he had managed to distract himself and think positively. Attendees assessed his risk of suicide as low and stopped the constant supervision, which meant the normal cell door was used. They reduced his ACCT monitoring to three observations an hour at irregular intervals.

66. On 12 August, CM A chaired an ACCT case review which a mental health nurse attended. He noted that Mr Quelch continued to have thoughts of suicide but was able to manage them and found prisoners and staff on the wing supportive.

Attendees assessed Mr Quelch's risk of suicide as raised and agreed to reduce his ACCT observations gradually. They started with two observations an hour, with one meaningful conversation every morning, afternoon and evening. (This frequency of conversations remained in place until Mr Quelch's death, but the conversations do not appear to have been recorded.) One action was added to the caremap: to set small goals to help improve wellbeing.

67. On 14 August, CM A chaired an ACCT case review which a SO and two nurses attended. The CM recorded that they discussed various ways in which Mr Quelch could distract himself from his 'dark thoughts' and that he agreed to press his cell bell and speak to someone if they became too much. Attendees assessed his risk of suicide as raised and reduced his observations to one an hour.

68. At 2.45am on 16 August, a CM chaired an ACCT case review after an operational support grade (OSG) reported that Mr Quelch was displaying strange behaviour. She recorded that Mr Quelch had paranoid thoughts and believed that he had overheard staff say that his 87-year-old grandmother had been arrested. She increased his observations to two an hour.

69. At 10.00am, CM B chaired an ACCT case review which an officer and a nurse attended. Mr Quelch said that he had difficulty sleeping which had led to him having paranoid thoughts. The CM established that Mr Quelch did not have much to do during the day and the officer agreed to increase his cleaning sessions so that he would get more time out of his cell. Attendees assessed his risk as raised and kept his observations at two an hour.

70. On 18 August, CM A chaired an ACCT case review which the psychiatrist and a mental health nurse attended. Mr Quelch said that he had been finding it difficult to sleep and that as a result, his mood had been up and down. He also said that he had handed in a plastic bag and a razor blade to staff. The CM recorded that the attendees told Mr Quelch that he had acted appropriately by giving them the items and spoke to him about building on his positive thoughts. Mr Quelch asked to move out of the safer cell, but attendees advised against it as the standard cells had many ligature points. They assessed his risk as raised and reduced his observations to one an hour.

71. On 20 August, the psychological wellbeing practitioner saw Mr Quelch for a wellbeing service review and recorded that he scored high for anxiety and feeling low. Mr Quelch said that his thoughts of suicide were always there and that he could not guarantee that he would not act on them as his mood remained variable. The practitioner noted this information in the ACCT ongoing record and planned to review him in one week.

Events from 23 to 25 August

72. At 9.05pm on 23 August, Mr Quelch asked to speak to a prison Listener (a prisoner trained by the Samaritans to support other prisoners) and staff escorted them to a confidential room. At 10.44pm, staff returned them to their cells.

73. The following morning (24 August), a SO reviewed Mr Quelch in response to him speaking to a Listener overnight and because his father had contacted the safer

custody hotline to express concerns about Mr Quelch's low mood. Mr Quelch told her that he had asked to speak to a Listener because he was feeling particularly low but that he was not seriously considering self-harm. She recorded that she did not have any immediate concerns about Mr Quelch and that she would call his father before his ACCT review later that day. However, there is no record that she did so.

74. At 10.00am, an officer recorded in the ongoing ACCT record that Mr Quelch had refused exercise and that this was unusual for him. At 11.35am, he noted that Mr Quelch had refused to have his lunch.

75. At 1.30pm, CM A chaired an ACCT case review which several members of staff, including a SO and a mental health nurse attended. The CM recorded that as Mr Quelch entered the room, he said that he was 'alright' and asked for the ACCT to be closed. When he was asked about this, it became apparent that he thought that being monitored under ACCT procedures meant that he would not be able to move cells. The CM explained that he could move if staff considered it appropriate. Mr Quelch told attendees that he had recently been feeling 'more up than down' but continued to have difficulty sleeping and had spoken to a Listener overnight. The CM noted that although attendees recognised that Mr Quelch appeared more positive, they did not feel that it was appropriate to stop ACCT monitoring. They therefore agreed to reduce his observations to one every two hours.

76. At 3.50pm, an officer spoke to Mr Quelch and recorded that he did not report any concerns. At 6.25pm, he noted that Mr Quelch had made two to three phone calls and refused a meal.

77. At 8.20pm, OSG A looked through Mr Quelch's cell observation panel to conduct an ACCT check and recorded that he was sitting on his bed. At 10.14pm, he conducted another ACCT check and noted that Mr Quelch was sitting on his bed watching television and turned to look at him. In his police statement, he said that Mr Quelch had turned his light off, but the cell was illuminated by the television.

78. At around 12.10am on 25 August, OSG A looked through Mr Quelch's cell door observation panel to conduct an ACCT check and saw him lying on his bed, with his feet towards the door. In his police statement, he said that, as the light on the television changed, he noticed that Mr Quelch had something covering his face. He said that he initially thought that Mr Quelch had put a towel over his eyes but when the light changed, he noticed that he had a plastic bag over his head. He said that he looked for signs of breathing and tried to rouse Mr Quelch by banging on the door, before radioing a medical emergency code blue. Control room staff immediately called an ambulance.

79. At 12.12am, CM B arrived at the cell and asked OSG A for his cell key. At 12.13am, he entered the cell, noted that Mr Quelch had a plastic bag over his head that was secured by an elastic band around his neck and removed it. He leant Mr Quelch forward to clear his airway and radioed for all available staff to attend. He started CPR while Mr Quelch was lying on his bed and asked the OSG to activate his body-worn video camera.

80. At 12.17am, an officer took over CPR and CM B left the cell. (The time on the body-worn camera footage was four minutes fast and we have adjusted the timings in this report accordingly.) At 12.19am, the CM returned to Mr Quelch's cell, asked staff if he had a pulse and left a minute later. At 12.24pm, the CM entered the cell with a defibrillator and attached it to Mr Quelch. The defibrillator did not detect a shockable rhythm and staff continued CPR.

81. At 12.32am, a paramedic arrived at the cell, assessed Mr Quelch and took over resuscitation efforts. At 12.36am, more paramedics arrived and moved Mr Quelch onto the landing for easier access. At 12.58am, a paramedic pronounced that Mr Quelch had died.

Contact with Quelch's family

82. At 2.19am, a prison governor tried to contact Mr Quelch's father, his named next of kin, by telephone but there was no answer. At 3.10am, after several more attempts to contact Mr Quelch's father, the governor asked the police for assistance and they visited his address to break the news of Mr Quelch's death. At 4.10am, a prison manager received a phone call from Mr Quelch's father and he offered his condolences and support.

83. The prison appointed a CM as the family liaison officer and an officer as her deputy. At 9.30am, the CM contacted Mr Quelch's father to offer support and to explain the next steps. That afternoon, Mr Quelch's family visited Bure and the CM and officer offered support.

84. The CM provided ongoing support to Mr Quelch's father until his funeral, which took place on 25 September. The prison contributed towards the cost in line with national policy.

Support for prisoners and staff

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

86. The prison posted notices informing other prisoners of Mr Quelch'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 Quelch's death.

Post-mortem report

87. A post-mortem examination found that Mr Quelch died from plastic bag asphyxiation.

88. Toxicology analysis of Mr Quelch's blood identified sertraline at levels above the therapeutic range. The post-mortem report concluded that it was possible that death occurred as a result of the combined effect of hypoxia (a lack of oxygen) caused by the asphyxiation, and an arrhythmia (an irregular heartbeat) caused by sertraline toxicity.

Findings

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

89. Prison staff appropriately began ACCT procedures after Mr Quelch tried to take his life on 24 July. There was much good practice. Staff made significant attempts to engage with Mr Quelch and took supportive action, such as involving his father. The ACCT case reviews were multidisciplinary and had good input from the mental health team, and staff generally responded to Mr Quelch's needs.

90. However, we do have some concerns about the management of the ACCT process.

Assessing the level of risk and setting observation levels

91. The ACCT document provides staff with guidance on how to assess the level of risk of suicide and self-harm. It says that risk is high, for example, when the prisoner has frequent suicidal ideas not easily dismissed, there is evidence of acute or ongoing mental illness, or there are escalating patterns of self-harm. Risk is raised when suicidal ideas are frequent but generally fleeting, there is evidence of acute or ongoing mental disorder, or there is current self-harming behaviour. Risk is low when suicidal thoughts are fleeting and there is no self-harming behaviour.

92. When Mr Quelch returned from hospital on 26 July, prison staff appropriately assessed his risk as high and placed him under constant supervision. However, we are concerned that when staff stopped constant supervision on 11 August, they assessed Mr Quelch's risk of suicide as low. At interview, a prison manager told the investigator that there was "no way" that Mr Quelch was at low risk of suicide and that he must have "ticked the low risk box by mistake".

93. PSI 64/2011 requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm and take appropriate action. Staff judgement is fundamental to the ACCT system, which relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. While a prisoner's presentation is obviously important and reveals something of their level of risk, it is only one piece of evidence in assessing risk. Staff should make a considered, objective evaluation of all risk factors when assessing the risk of suicide and self-harm.

94. Although staff increased Mr Quelch's risk of suicide to 'raised' on 12 August, we are concerned that they failed to consider all his risk factors and as a consequence, underestimated his risk of suicide. When assessing Mr Quelch, there is no record that attendees fully considered that he continued to report suicidal ideas that did not appear to be easily dismissed or his difficulty in managing his negative thoughts at night – both factors that might have increased his risk.

95. When Mr Quelch handed in a razor blade and plastic bag to staff on 18 August, staff rightly praised him for his actions and focussed on the positives. However, there is no record that they also considered that this it might have indicated that he was actively considering another suicide attempt and whether they should

monitor his access to plastic bags. This is particularly concerning given Mr Quelch's suicide attempt in July had involved a plastic bag.

96. We are also concerned that staff placed too much emphasis on the positives and Mr Quelch's assertion that he was feeling "more up than down" when deciding to reduce his ACCT observations on 24 August. CM A told us that he took account of Mr Quelch's improved outlook and that he that the fact he had asked for a Listener was a positive factor.

97. We agree that asking for a Listener was a positive move in some ways in that it suggested that Mr Quelch was trying to manage his negative thoughts without self-harming. However, the fact that he had needed to ask for a Listener and had spent more than one and a half hours talking to him, also indicated that Mr Quelch was still having negative thoughts at night and was having difficulty managing them. We note that Mr Quelch had told a SO that morning that he had needed to speak to a Listener because he had been feeling particularly low.

98. We are concerned that attendees at the review on 24 August failed to recognise this and did not take into account that Mr Quelch's father had contacted the prison that morning to express concern about his son's low mood. We consider that attendees placed too much weight on what Mr Quelch said about feeling 'more up than down', especially as it appears Mr Quelch may have said this because he thought it would enable him to move to a different cell. As a result, we consider that they misinterpreted Mr Quelch's risk and inappropriately reduced his observations.

Completing and recording conversations

99. PSI 64/2011 states that staff must follow the level of conversations stated on the ACCT document and must record these immediately or as soon as is practical. It also states that staff must actively engage with the prisoner, encouraging them to talk and participate in activities, where appropriate.

100. There is no evidence that wing staff held good quality conversations with Mr Quelch at the required frequency, and most of their recorded interactions with him were brief. Mr Quelch spent much of his time in his cell because of the restricted COVID-19 regime and often reported struggling with his 'dark thoughts'. In these circumstances, it is particularly important that staff try to engage with a vulnerable prisoner.

101. We recommend that:

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

- **case reviews consider all relevant information that affects risk, and staff only reduce the frequency of observations when there is evidence that the risk has reduced; and**
- **conversations are carried out as directed and documented in the ongoing record.**

Emergency response

102. PSI 24/2011, *Management and Security of Nights*, states that staff have a duty of care to prisoners, to themselves, and to other staff, and that preservation of life must take precedence over usual arrangements for opening cells. It says that where there is or appears to be immediate danger to life, then a single member of staff can enter the cell alone, after performing a rapid dynamic risk assessment.

103. OSG A acted promptly and appropriately called an emergency medical code blue when he found Mr Quelch with a bag on his head. However, he waited outside until additional staff arrived and did not enter Mr Quelch's cell. In his police statement, he said that he did not enter the cell because he thought Mr Quelch might be trying to trick him into unlocking the door so he could escape or attack him.

104. We recognise that officers must have regard for their own safety, and we cannot say that OSG A should have entered the cell. However, we note that Mr Quelch was subject to ACCT monitoring, had previously tried to take his life by the same method and did not have a history of assaulting staff.

105. After CM B entered the cell and removed the plastic bag from Mr Quelch, he started giving chest compressions while Mr Quelch was on his bed. The efforts to resuscitate him on his bed continued until paramedics arrived and took control of the situation. European Resuscitation Council Guidelines for Resuscitation 2015 state that resuscitation should be performed on a firm surface wherever possible. We therefore consider that prison staff should have moved Mr Quelch onto the floor of his cell or the unit landing to perform CPR.

106. We are also concerned that prison staff who responded to the code blue did not bring a defibrillator and that it took 14 minutes for one to be brought to Mr Quelch's cell. PSI 03/2013 requires staff to bring all equipment relevant to the nature of the emergency.

107. CM B told us that he left the cell to call the control room and to collect a defibrillator. However, he failed to explain why he returned to the cell without a defibrillator at 12.19am, before returning with a device five minutes later. He also said that although defibrillators were located on each unit, staff did not always take one to a code blue. A defibrillator is a critical piece of life saving equipment that we consider should be taken every time a medical emergency code is called.

108. We cannot say if these delays may have affected the outcome for Mr Quelch, but he would have had access to emergency care and equipment sooner.

109. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that staff:

- **enter cells as quickly as possible in life-threatening situations;**

- **undertake resuscitation on a hard surface, where this is achievable and without delaying the start of CPR; and**
- **take a defibrillator to medical emergencies.**

Clinical care

110. The clinical reviewer found that although the physical health care that Mr Quelch received at HMP Bure was of a satisfactory standard, the mental health care he received was not equivalent to that which he could have expected to receive in the community.

Initial health screens

111. Prison Service Order (PSO) 3050 on the continuity of healthcare for prisoners requires that, when a new prisoner arrives in reception, prison staff try to obtain relevant information from the prisoner's GP or other health services with whom the prisoner has recently been in contact.

112. The clinical reviewer considered that healthcare staff relied too heavily on Mr Quelch, who provided inconsistent information. When Mr Quelch arrived at Bure, healthcare staff did not review his medical record from Pentonville. As a result, they accepted Mr Quelch's assertion that he did not have a recent history of self-harm. This meant that staff missed an opportunity to identify Mr Quelch's previous self-harming behaviour and to offer support.

Mental health care

113. When the mental health nurse assessed Mr Quelch on 15 November 2019, she did not record whether she reviewed his medical record beforehand. At interview, she told us that she could not remember the meeting. We have concluded that it is unlikely that she did review Mr Quelch's medical record since, when a colleague subsequently realised in January 2020 that Mr Quelch had a possible diagnosis of ADHD, Mr Quelch was promptly added to the secondary care team's caseload for support with ADHD. We would have expected the same thing to have happened if she had been aware of the possible ADHD diagnosis.

114. We, therefore, consider that the mental health nurse's assessment was insufficiently thorough and that this was a missed opportunity to ensure that Mr Quelch received early support from mental health staff. In addition, we are concerned that Mr Quelch was prescribed atomoxetine without confirmation of an ADHD diagnosis.

115. The clinical reviewer was also concerned that a psychiatrist did not see Mr Quelch for a one-to-one review after he returned from hospital on 26 July following his serious suicide attempt. Although the psychiatrist attended three ACCT case reviews, he only assessed Mr Quelch in this setting. The clinical reviewer considered that he should have seen Mr Quelch for an assessment separate from the ACCT process as this would have enabled him to conduct a full assessment of his mental state and to discuss his treatment options. The psychiatrist told us that he did not consider seeing Mr Quelch in clinic as he had seen him in ACCT review, but he recognised that he could have instructed nurses to book him a clinic appointment.

116. We recommend:

The Head of Healthcare should ensure that healthcare staff:

- **review a prisoner's existing medical record as part of the initial screening process; and**
- **conduct mental health assessments separately from the ACCT process.**

Prescribed medication

117. The clinical reviewer also considered that healthcare staff should have reviewed Mr Quelch's sertraline prescription. Although Mr Quelch took the medication for at least 12 months and was prescribed the maximum dose, there is no evidence that healthcare staff completed regular medication reviews in line with National Institute for Health and Care Excellence (NICE) guidance. The clinical reviewer also noted that regular medication reviews might have resulted in a change of medication, which could in turn have, benefited Mr Quelch's mood and helped with his sleep problems.

118. The post-mortem report revealed levels of sertraline in Mr Quelch's blood that far exceeded the therapeutic range and concluded that it was possible that sertraline toxicity contributed to his death.

119. Following Mr Quelch's suicide attempt in July, staff appropriately decided to dispense Mr Quelch's medication daily rather than allowing him to keep it in his cell. However, the levels of sertraline found at post-mortem suggest that Mr Quelch may have been stockpiling his prescribed medication and took a deliberate overdose. There is no record that staff had any concerns about him stockpiling or that he was observed concealing his medication. This raises the question of whether there was adequate supervision of Mr Quelch when he was given his sertraline each day.

120. We recommend:

The Head of Healthcare should ensure that healthcare staff:

- **regularly review prisoners' prescribed antidepressant medication, in line with NICE guidelines;**
- **record the reasons for prescribing any medication for an illness that has not been formally diagnosed;**
- **supervise the dispensing of medication closely when a prisoner is being managed under ACCT procedures.**

Learning Lessons

121. We have identified a number of concerns in this report. We consider it is important that staff learn from our findings. We recommend the following:

The Governor and Head of Healthcare should ensure that a copy of this report is shared with the prison manager, CM A, CM B, OSG A, the

consultant psychiatrist and the mental health nurse, and that a senior manager discusses the Ombudsman's findings with them.

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