Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Clacher a prisoner at HMP Guys Marsh on 21 March 2018

A report by the Prisons and Probation Ombudsman

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

Our Vision

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

Our Values

We are:

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

© Crown copyright 2022

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Anthony Clacher was found hanged in his cell at HMP Guys Marsh on 21 March 2018. Mr Clacher was 36 years old. I offer my condolences to Mr Clacher's family and friends. I apologise for the delay in issuing my report.

Mr Clacher had a history of substance misuse, depression and post-traumatic stress disorder (PTSD). At 4.20pm on 21 March, staff found him apparently under the influence of psychoactive substances (PS). Healthcare staff assessed him and returned him to his cell when they were satisfied he was well enough to do so. He was found hanged about two hours later. The toxicology report showed he had taken PS before he died.

I am satisfied that staff did not have any reason to believe that Mr Clacher was at risk of suicide on the day of his death.

Mr Clacher's was the first of four deaths at Guys Marsh between March and June 2018 in which PS played some part. While the prison has taken measures to tackle the issue, more needs to be done. Her Majesty's Inspector of Prisons found that drugs are still too readily available in the prison. I repeat the concerns I have expressed in too many investigations about the number of deaths my office investigates in which PS has played at least some part. Mr Clacher's death is another example of how dangerous PS is and how prisons are struggling to reduce PS use.

I am concerned that individual prisons are being left to develop local strategies to reduce the supply and demand for drugs. In my view, there is now an urgent need for national guidance on the best measures to combat this serious problem. We have already made a recommendation to this effect to the Chief Executive of HM Prison and Probation Service. We have also written to the Prisons Minister setting out our concerns at the number of drug-related deaths in custody.

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 **May 2019**

Contents

Summary 1

The Investigation Process 3

Background Information 4

Key Events 6

Findings 13

Summary

Events

1. Mr Anthony Clacher had a history of substance misuse, depression and post-traumatic stress disorder (PTSD). In October 2017, he was sentenced to two years imprisonment for theft and was taken to HMP Bullingdon. Staff at Bullingdon suspected he was under the influence of psychoactive substances (PS) on four occasions.

2. On 8 March 2018, Mr Clacher was transferred to HMP Winchester, and HMP Guys Marsh on 14 March 2018. Mr Clacher was managed under Prison Service suicide and self-harm monitoring procedures (known as ACCT) across all three prisons between 13 January and 19 March 2018.

3. On 19 March, ACCT procedures were stopped and Mr Clacher was moved to a single cell on Dorset unit, a standard wing.

4. On the morning of 21 March, an officer suspected that Mr Clacher might be under the influence of PS but he denied it and a substance misuse worker who saw him at about 2.40pm had no concerns about him.

5. At 4.20pm, staff found Mr Clacher apparently under the influence of PS, halfway down the unit stairs. Healthcare staff examined him and officers helped him back to his cell 14 minutes later when they were satisfied he was well enough to do so. At 6.58pm, an officer delivering mail found him hanged in his cell.

6. Staff and paramedics gave Mr Clacher emergency aid but at 7.55pm, a doctor confirmed that he had died.

Findings

7. Mr Clacher's death appears to have been linked to his PS use, but we cannot say whether he took the decision to hang himself as a result of the mind-altering effects of the drug, or because he was being bullied over drug-related debts, or for some other reason.

8. When Mr Clacher died, Guys Marsh prison was overwhelmed by PS and their strategy to reduce supply and demand was not sufficiently well developed. The prison did not have a consistent policy of monitoring the wellbeing of prisoners found under the influence of PS.

9. In response to these deaths, Guys Marsh developed a number of strategies targeting supply disruption, monitoring offenders who have taken PS and working with them afterwards to address their behaviour and keep them safe. At the time of writing this report, these strategies were not yet embedded and, in January 2019, Her Majesty's Inspector of Prisons (HMIP) found that drugs were still too readily available in Guys Marsh.

10. Staff on Mr Clacher's unit had developed the poor practice of not looking through the observation panel to check what the prisoner was doing before unlocking their cells. This meant the one opportunity to check on Mr Clacher's welfare shortly before he was found hanged, was lost.

11. We identified some procedural concerns with Mr Clacher's management under ACCT procedures, including that ACCT monitoring was stopped before all the actions on the caremap were completed. However, we do not consider that staff had any reason to believe that Mr Clacher was at risk of suicide on the day he hanged himself.

12. Overall, the emergency response was good. An emergency code was called but there was a short delay before an ambulance was called. This did not affect the outcome for Mr Clacher as assistance was prompt and well done. Since Mr Clacher's death, the prison has re-issued guidance to staff on emergency codes, placed emergency equipment on every unit and introduced customised Intermediate Life Support (ILS) training for custodial managers.

13. We identified that national guidance on using body-worn cameras (BWCs) to record lifesaving medical intervention was not embedded at Guys Marsh. We do not criticise the staff concerned.

Recommendations

- The Chief Executive of HMPPS should provide the Ombudsman with a revised date for issuing detailed national guidance on measures to reduce the supply and demand of drugs in prisons, and an assurance that this new date will be met.

- The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

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

  - ACCT caremaps should have specific, meaningful actions aimed at reducing prisoners' risk to themselves and progress should be considered and documented at each review.

  - All caremap actions have been completed before ACCT monitoring is stopped.

- The Governor reminds staff of the guidance in PSI 04/2017 about the unobtrusive use of body-worn cameras in lifesaving medical intervention.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Guys Marsh informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded and was interviewed.

15. The investigator obtained copies of relevant extracts from Mr Clacher's prison and medical records. She watched body-worn camera footage from 21 March. Neither CCTV nor the emergency radio traffic were available. She liaised with Dorset police and obtained copies of statements from their investigation.

16. The investigator interviewed 14 members of staff and five prisoners at Guys Marsh in June and July 2018. One prisoner declined to be interviewed because he was under the influence of PS. She also reviewed confidential security intelligence in the security department and visited Dorset unit.

17. NHS England commissioned a clinical reviewer to review Mr Clacher's clinical care at the prison. The clinical reviewer interviewed seven members of staff with the investigator.

18. We informed HM Coroner for Dorset 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. The investigator contacted Mr Clacher's sister, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Clacher's sister said she wanted to know as much as possible about the events of the day Mr Clacher died, especially in the couple of hours before he was discovered hanged.

Background Information

HMP Guys Marsh

20. Guys Marsh is a medium security prison that holds up to 579 men. Care UK provides primary and secondary mental healthcare and has commissioned another agency, EDP, to provide integrated substance misuse services. Healthcare services are available on weekdays and at weekends from 8.30am to 6.00pm and there is a doctor on duty on Saturday mornings.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Guys Marsh was in January 2019. The report was not available at the time of writing but initial feedback showed that some improvements had been made to reduce the supply of illicit drugs, but it remained high. Many good initiatives were relatively recent and were not yet sufficiently embedded. Suspicion testing was being carried out in a timely fashion but target searching in response to intelligence was often not taking place. Drugs were still too readily available in the prison. There had been a great deal of attention to reducing the supply of illicit drugs, with appropriate use of dogs and technology, but too many of these initiatives were less than a year old and not yet sufficiently embedded. There was a good range of psychosocial support with 50% of the population actively engaging with services.

22. Following a previous inspection in 2016, Guys Marsh was placed in special measures and remains in special measures at the time of writing (February 2019). 'Special measures' means HM Prisons and Probation Service has determined a prison needs additional, specialist support to improve performance.

Independent Monitoring Board

23. 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 November 2017, the IMB noted that there were staff shortages and the availability of psychoactive substances (and other illegal drugs) led to debt which in turn impacted on safety, security and decency.

Previous deaths at HMP Guys Marsh

24. The deaths of two prisoners at Guys Marsh in March and September 2016, involved illegal drugs. There are some similar issues between the death in September 2016, and that of Mr Clacher, including substance misuse and obscuring observation panels. Three prisoners died at Guys March after Mr Clacher, one in April and two in June 2018. Psychoactive substances were a contributory factor in all of them. We repeat a recommendation to the Chief Executive of HMPPS about national guidance on reducing drugs in prisons.

Psychoactive Substances (PS)

25. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

26. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

27. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

ACCT

28. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

29. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

30. 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

31. Mr Anthony Clacher had a history of misusing prescription and non-prescription drugs, including methadone, heroin, crack cocaine, cannabis and hallucinogenics. Mr Clacher was diagnosed with post-traumatic stress disorder (PTSD) and a personality disorder in 2006. His GP notes also recorded a deliberate overdose of paracetamol in 2006. He had been in prison before.

32. Throughout his final prison sentence, Mr Clacher said that he had been prescribed olanzapine (an anti-psychotic) and procyclidine (prescribed to reduce the side effects of anti-psychotics) outside prison. There is no evidence in his GP notes or his prison medical record that he had been diagnosed with psychosis or had ever been prescribed these drugs.

HMP Bullingdon 13 October 2017 – 8 March 2018

33. On 13 October 2017, Mr Clacher was sentenced to two years imprisonment for theft and was taken to HMP Bullingdon. At an initial health assessment, he tested positive for methadone (which he was prescribed), opiates and cocaine. Mr Clacher told the prison GP that he had been prescribed olanzapine a year previously but was not currently on any medication. He was subsequently assessed by the substance misuse team who continued prescribing him methadone on a reducing dose. Mr Clacher said that he did not want to work on his substance misuse issues with the psychosocial team.

34. Later the same day, staff discovered Mr Clacher standing with his eyes closed, bleeding from one arm and verbally unresponsive. He was admitted to the prison inpatient unit. Mr Clacher denied taking any illicit substances or feeling suicidal and he said he was hearing voices because he was not taking his antipsychotic medication. Staff began Prison Service suicide and self-harm monitoring, known as ACCT, because he had made superficial cuts to his arm. He was referred for a mental health assessment and was prescribed promethazine (sleeping tablets).

35. On 15 January, Mr Clacher opened the cuts on his arm when he was told he was going back to a standard wing. He told a GP that his mental health was deteriorating and he was hearing voices. He said that he was being bullied on the wing and had been forced to pay £2,000 for drug debts. Mr Clacher said that he felt safe on the inpatient unit.

36. On 16 January, Mr Clacher was moved to a standard wing but was readmitted to the inpatient unit the next day after cutting his arms again. He also tested positive for PS in a random drug test. The mental health in-reach team reviewed him at a multidisciplinary meeting the same day. They found no evidence that he had ever been prescribed anti-psychotic medication. They concluded it would be inappropriate to prescribe such medication because Mr Clacher had no history or evidence of psychosis and wing staff suspected him of ongoing illicit substance misuse (which carried the risk of harmful interaction with prescribed drugs). They thought Mr Clacher's voices were related to childhood trauma exacerbated by illicit substance misuse. They concluded that Mr Clacher's illicit drug use and methadone detoxification meant that he was not at an appropriate stage to benefit from support from the prison psychiatrist.

37. On 22 January, Mr Clacher cut his arms again when staff proposed he return to a standard wing. A prison GP prescribed fluoxetine (an anti-depressant). On 7 February, intelligence was received that Mr Clacher was one of a number of prisoners suspected of obtaining illicit substances via a prisoner who visited the in-patient unit regularly for treatment. On 24 February, Mr Clacher started a short course of zopiclone (sleeping tablets). On 28 February, Mr Clacher returned to a standard wing.

38. On 1 March, Mr Clacher cut his arm with a razor but he was not reviewed under ACCT procedures as he should have been. On 7 March, he said that he felt calmer on the wing since his self-harm. He also said that he finished his methadone detoxification soon and hoped to start medication for his mental health after that. During the night, he was found slurring his words and unsteady on his feet. When nurses came to his cell to examine him he was unresponsive and shaking on his bed. He received appropriate treatment.

HMP Winchester 8 – 14 March 2018

39. The next morning, on 8 March, Mr Clacher appeared at a crown court on an outstanding charge of theft. He received a six-week sentence to be served concurrently with his existing sentence and was taken to HMP Winchester. A nurse noted at his initial health assessment that he was taking 5mg methadone and 40mg fluoxetine a day. He said he had not self-harmed in the last year. Mr Clacher was unable to provide a urine sample to test for methadone and illicit drug use. He agreed to psychosocial intervention and support from the substance misuse service.

40. On 10 March, Mr Clacher was assessed by a Community Psychiatric Nurse. Mr Clacher said he cut his arms to manage his emotions and had attempted suicide by drug overdose 14 years previously. He did not report any symptoms of mental illness.

41. ACCT procedures were not reviewed at Winchester until 14 March, when Mr Clacher was about to be transferred to HMP Guys Marsh. Mr Clacher said that he was looking forward to moving to Guys Marsh because it was closer to where he lived. He said he had no thoughts of suicide or self-harm but said that he still heard voices “now and then”. The mental health nurse that attended the review noted in Mr Clacher’s medical record that she had not seen any evidence of perceptual or psychotic features in Mr Clacher’s behaviour.

HMP Guys Marsh 14 – 20 March

42. Mr Clacher told an assistant practitioner at an initial health assessment that he was on methadone and had self-harmed recently, and he asked for a referral to the mental health team because he had a history of PTSD and depression. He said that he was hearing voices and had been on anti-psychotic medication in the past. The assistant practitioner sent a referral to the Primary Mental Health Team (PMHT). A GP continued Mr Clacher’s prescriptions for zopiclone and fluoxetine.

43. On 16 March, a custodial manager (CM) and the nurse manager, reviewed Mr Clacher’s ACCT. Mr Clacher said he had been taken off olanzapine at

Bullingdon to complete his methadone detoxification. (This was not the case.) As this was now finished, he wanted to be referred to the mental health team so he could restart olanzapine. Mr Clacher said he was happy to be at Guys Marsh because it was closer to where he lived. He felt his ACCT could be closed. The CM said he was unwilling to do this without a mental health nurse being present. The CM and the nurse manager, decided to reduce observations to twice in the morning, twice in the afternoon, twice in the evening and four times overnight. The CM scheduled another review for 19 March, with a view to a mental health nurse attending and the ACCT possibly being closed.

44. The nurse manager chased up Mr Clacher's referral to the PMHT and asked for it to be actioned. On 19 March, the next working day, a nurse reviewed Mr Clacher's record and put him on the waiting list for a mental health assessment.

45. A CM and a reverend reviewed Mr Clacher's ACCT on 19 March in the prison chapel. The CM said that he had not met Mr Clacher before. He read his ACCT document before the review and noticed that another CM had not closed it at the previous review because there had been no input from the mental health team. The CM rang the healthcare department to try to get a mental health nurse to attend. He said no one was available so he asked for relevant information by telephone. A nurse told him that the mental health team were aware of Mr Clacher and planned to assess him.

46. Mr Clacher said he had no current thoughts of self-harm. He said he was about to move to a single cell on Dorset unit, felt positive and was looking forward to being released on home detention curfew (HDC) in May. A CM said Mr Clacher's main concern was his mother who was in hospital. He said he held the review with a reverend because the reverend had already spoken to Mr Clacher about arranging an escorted visit to see his mother on compassionate grounds. The CM said he was satisfied that Mr Clacher appeared positive and that plans were in hand for him to see the mental health team and visit his mother. He marked the actions on the caremap complete and closed the ACCT. Mr Clacher was moved to cell C43 on Dorset unit the same day.

47. A prisoner was located in cell C46 a couple of doors away from Mr Clacher's. He said he spoke to Mr Clacher about four or five times during the two days Mr Clacher was on Dorset unit. He said that Dorset unit had good staff but there was a high concentration of prisoners involved in gangs and supplying drugs in prison. He said 'guinea pigging' took place regularly and it was common for prisoners under the influence of drugs to be made fun of or beaten up. He said that these incidents were often filmed and shared on social media via mobile phone. He described a "three toke challenge" where prisoners inhaled PS three times in succession and, if they did not pass out, they did not have to pay for it.

48. The prisoner said that on 20 March he saw about five or six other prisoners in Mr Clacher's cell as he walked past. Mr Clacher and some of the others looked under the influence of PS. As he walked past, he saw one of the prisoners put a noose around Mr Clacher's neck. He stopped to look and one of the prisoners said, "We're only joking." He did not tell staff.

21 March 2018

49. At about 8.30am on 21 March, a prisoner said he saw Mr Clacher go to another prisoner's cell and ask for "an ounce of Spice". He said the other prisoner agreed to give Mr Clacher the drugs but asked for the money by dinner time "or else". At lunchtime around 12.30pm, he said he saw Mr Clacher staggering around and other prisoners were laughing at him. He said that it all seemed to be good humoured, so he did not tell staff.

50. An officer saw Mr Clacher for the first time that day at lunch and thought his eyes looked glassy. She asked the acting custodial manager (ACM) of Dorset unit, to check him because she was not familiar with Mr Clacher and did not know what he usually looked like. At about 1.30pm, the ACM and a Supervising Officer (SO) went to Mr Clacher's cell. Mr Clacher told them he was fine and he denied having taken PS or any illicit substance. The ACM said that Mr Clacher was coherent and he did not appear to be under the influence of any substance.

51. At about 2.40pm, a family worker completed an initial assessment with Mr Clacher on Dorset unit. She was the duty substance misuse team member that day and had not met Mr Clacher before. She said he was clean, polite, relaxed and chatty. Mr Clacher said that he was keen to address issues related to his long-term drug use. He had recently completed a methadone detoxification but was still having problems sleeping and was unsure whether he had been prescribed zopiclone. He asked her to check the progress of his mental health referral but she said that he did not seem particularly concerned about it.

52. They completed the harm minimisation sheet, which contains information about the dangers of PS use, and a risk questionnaire. Mr Clacher denied using PS. A family worker said he did not look like a PS user, he was a healthy colour, his eyes were clear and he did not smell of PS. Mr Clacher said he had attempted suicide about 18 years previously and sometimes cut himself but he had not done so for over a year. He said he had no current thoughts of suicide or self-harm. He was looking forward to being released on home detention curfew in May and hoped to return to his flat.

53. After their conversation, Mr Clacher telephoned his mother. The investigator listened to the recorded call. There is nothing to suggest that Mr Clacher was feeling suicidal. Mr Clacher's mother told the prison family liaison officer that he had sounded fine when she spoke to him.

54. A prisoner returned to Dorset unit from work at about 4.20pm. He said that Mr Clacher was in a worse state than earlier and other prisoners were throwing food and milk at him. The staff were preparing the servery for the teatime meal or in the office.

55. An officer said that he heard a number of prisoners laughing and shouting. He found Mr Clacher lying immobile half way down the stairs. He moved Mr Clacher to the bottom of the stairs with an officer and radioed for a nurse. The ACM heard the radio call and went to investigate. He said that Mr Clacher was rigid and was talking nonsense. Body-worn camera footage shows Mr Clacher lying on the floor at the bottom of the stairs at 4.20pm.

56. An assistant practitioner and a healthcare assistant responded at 4.21pm. Mr Clacher's pulse was 144 (which is high) and his oxygen levels were 94% (which is low but not critically low). The assistant practitioner said his pupils were very large and he appeared to be hallucinating because he was talking to a bin. She could see no sign of physical injury or trauma and said his behaviour was consistent with PS use. After a while, Mr Clacher's oxygen level returned to 98% (normal) and at 4.31pm, the officers sat him up. The assistant practitioner said he was still hallucinating but she was "happier with his colour".

57. The healthcare assistant said a number of other prisoners were cheering and jeering during the incident. One of them said, "He was like this earlier Miss, he'll be okay, he had a plastic bag on his head." Several prisoners also advised them to give Mr Clacher an orange.

58. At 4.32pm, the ACM and an officer helped Mr Clacher upstairs. At the top of the stairs Mr Clacher seemed steadier and he was able to walk unaided to his cell. At 4.34pm they locked him in his cell.

59. The assistant practitioner said that she thought she told the healthcare assistant check Mr Clacher regularly, as was her usual practice, but she could not remember. The healthcare assistant said she was talking to another prisoner and did not hear what the assistant practitioner said to the ACM. The ACM said the assistant practitioner did not tell him to check on Mr Clacher.

60. The Daily Occurrence Record showed evening unlock started at 6.19pm. An officer unlocked the cells on the ground floor and another officer unlocked Mr Clacher's landing. He said he did not remember unlocking Mr Clacher's cell. An officer said that, at that time, officers simply unlocked each door and moved quickly to the next cell without looking through the observation panel.

61. Shortly before 7.00pm, an officer said that he noticed that the prisoners' mail had not been handed out. When he arrived at Mr Clacher's cell, the door was shut with the main lock open and the privacy lock on. (The doors on Dorset unit have two locks: the main lock and a privacy lock that the prisoner has a key for. At unlock, officers unlock the main lock but not the privacy lock. Officers have a master key to the privacy locks in case they need to go into a cell. If a prisoner has the privacy lock on, other prisoners are not able to enter the cell.) The officer said he knocked and opened the door slowly because the observation panel was blocked and he did not know who was in the cell. He found Mr Clacher fully suspended from the ceiling light by a sheet.

62. An officer radioed a code blue emergency (indicating a prisoner has breathing difficulties or is unconscious) and supported Mr Clacher's body to try to reduce the pressure on his neck. The control room operational support grade recorded the officer's call at 6.58pm. Another officer responded first. He said that Mr Clacher's hands were tied behind his back and he had the clear plastic bag from his bin over his head. He immediately removed the bag from Mr Clacher's head and cut him down. They laid him on the bed and an officer removed the material from around Mr Clacher's wrists.

63. An officer checked Mr Clacher's airway, which appeared to be clear, and began cardiopulmonary resuscitation (CPR). He said he had received life support

training the week before. The other officer checked for a pulse but could not find one. He said his first impression was that Mr Clacher had died.

64. A CM, who was the orderly officer for the prison that evening, made his way to Mr Clacher's cell from the control room as soon as he heard the code blue call. He passed two officers running in the opposite direction to collect a defibrillator. (At the time the prison had two defibrillators, one in the prison gym and one in healthcare. Healthcare staff had gone off duty.) The CM found an officer doing chest compressions and began to give Mr Clacher rescue breaths. The CM said his first impression was that Mr Clacher had died. He turned on his body-worn camera. Timings are taken from this, and South West Ambulance Service (SWAST) records.

65. Another CM arrived at 7.01pm, and radioed the control room to call an ambulance. The control room log and SWAST records showed that the emergency call was made and received at 7.01pm. An officer who was a first aid instructor, brought the defibrillator from the prison gym at 7.07pm.   He moved Mr Clacher to the floor for more effective chest compressions and helped give him CPR. The defibrillator checked Mr Clacher and instructed them to continue CPR.

66. At 7.12pm, the first response paramedic arrived, checked Mr Clacher for signs of life and attached her own defibrillator. At 7.16pm, she said that she thought Mr Clacher was beyond help but he was warm and there was no sign of rigor mortis so they continued CPR. Two more ambulance paramedics arrived at 7.27pm, and at 7.41pm, another paramedic and a doctor arrived. Resuscitation was stopped at 7.51pm and at 7.55pm, the doctor confirmed that Mr Clacher had died.

Information received after Mr Clacher's death

67. After Mr Clacher died, the prison received information from several prisoners that Mr Clacher had been bullied and threatened because of drug debts and that prisoners on Dorset unit were being pressurised to take PS and then humiliated for the entertainment of others.

68. As a result, the prisoners identified as the main suppliers of drugs were transferred to other prisons.

Contact with Mr Clacher's family

69. An operational manager drove to the hospital where Mr Clacher's mother was receiving treatment. She broke the news of Mr Clacher's death in the presence of a nurse. Mr Clacher's mother died in April 2018.

Support for prisoners and staff

70. After Mr Clacher's death, the 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.

71. The prison posted notices informing other prisoners of Mr Clacher's death, and to offer support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Clacher's death.

Post-mortem report

72. The pathologist concluded Mr Clacher died from ligature suspension (hanging). Toxicology tests showed the presence of methadone, zopiclone, fluoxetine and synthetic cannabinoids (PS).

73. Based on the levels of methadone and zopiclone in Mr Clacher's blood, the toxicologist thought it likely that these were remnants from Mr Clacher's last prescribed doses of each. Mr Clacher was prescribed fluoxetine for depression and anxiety and the levels in his blood were consistent with therapeutic use.

74. The pathologist commented that, if Mr Clacher had used PS shortly before hanging himself, he was likely to have experienced effects including euphoria, anxiety, agitation and vivid hallucinations.

Findings

Monitoring prisoners found under the influence of PS

75. The PPO's Learning Lessons Bulletin on PS, issued in July 2015, highlighted that not only does PS use have a profoundly negative impact on physical and mental health, but use of them can lead to debt, violence and intimidation. Prisoners under the influence of PS are also vulnerable to humiliation for the enjoyment of other prisoners. Additionally, PS use has been linked with precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm. Mr Clacher's death is a clear example of how dangerous PS is.

76. There is no specific national guidance on monitoring prisoners following a PS incident, although we know prisons that have formal or informal monitoring. When Mr Clacher died, Guys Marsh had no local instruction or consistent local practice of monitoring prisoners after PS incidents. An assistant practitioner said that it was her usual practice to ask staff to check prisoners regularly but did not remember telling a CM, who was managing the incident, to do so. The CM said he was not given any instruction to monitor Mr Clacher after he was returned to his cell on 21 March.

77. The dangers of PS to physical and mental health make it prudent that prisoners are monitored following use, especially prisoners like Mr Clacher who had a history of mental illness and self-harm.

78. On 12 April 2018, the Governor introduced a new policy of welfare checks on prisoners found under the influence of PS. (Notice to Staff 70/2018 and Notice to prisoners 35/2018, 'Illicit Substances Welfare Checks'.) Prisoners under the influence are checked every 15 minutes for the first three hours and hourly thereafter until 8.00am, the following morning. Checks are recorded on a customised support document.

79. The Head of Healthcare has also implemented a Psychoactive Substances Pathway. This includes guidance to healthcare staff about best practice and continued support. We are satisfied that Guys Marsh have taken appropriate action on this matter since Mr Clacher's death and therefore, we make no recommendation.

Guys Marsh's Drug Strategy

80. Mr Clacher's death appears to have been linked to his PS use, but we cannot say whether he took the decision to hang himself as a result of the mind-altering effects of the drug, or because he was being bullied over drug-related debts, or for some other reason.

81. It is apparent that, at the time Mr Clacher died, Guys Marsh did not have a coordinated or sufficiently well-developed strategy for reducing the supply and demand of PS. Statistics collected by the prison at the time, showed PS use was widespread, although at interview staff and prisoners thought that Dorset unit had a particularly high concentration of suppliers. On the day he died, it appears that Mr Clacher was able to obtain PS and use it at least twice.

82. Overall, our investigation into Mr Clacher's death and those of the three prisoners who died after him in 2018, found that the prison is undertaking a number of measures to tackle the problem of PS. We accept that the prison has a drug strategy in place and staff are working hard to implement it. We have seen clear evidence of a desire from senior management to combat the PS problem and of custodial and healthcare staff working alongside each other to so.

83. Nevertheless, the recent HMIP report indicated that drugs are still easily accessible to prisoners at Guys Marsh and that these initiatives are not yet embedded. It is clear, therefore, that more needs to be done to reduce both the supply and the demand for PS.

84. Guys Marsh is not alone in facing this problem – it is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies. However, in the PPO's view there is an urgent need for national guidance to prisons from HMPPS providing evidence-based advice on what works.

85. In a number of recent investigations, we recommended that the Chief Executive of HM Prison and Probation Service (HMPPS) should issue detailed national guidance on measures to reduce the supply and demand of drugs, including PS, in prisons. The Acting Ombudsman also wrote to the Prisons Minister raising her concerns about the high number of deaths she was investigating that were due, or linked, to the use of PS. The Chief Executive told us that HMPPS planned to issue a national drug strategy in the autumn of 2018. We are concerned that at the time of writing (February 2019), this strategy has still not been issued. We therefore make the following recommendation:

The Chief Executive of HMPPS should provide the Ombudsman with a revised date for issuing detailed national guidance on measures to reduce the supply and demand of drugs in prisons, and an assurance that this new date will be met

Unlocking procedures

86. We do not know exactly when Mr Clacher's cell was unlocked during the evening of 21 March, but the daily occurrence book showed evening unlock began across the prison at 6.19pm. None of the Dorset unit officers interviewed remembered unlocking Mr Clacher's cell, but they acknowledged that a practice of turning the key and moving on to the cell next door without looking through the observation panel had developed.

87. For their own safety, officers are supposed to look at and make contact with a prisoner through the observation panel before opening a locked cell door. It is also supposed to be a check on the prisoner's wellbeing. We do not know if Mr Clacher was hanging at this point but this opportunity to check on his wellbeing was lost as a result of bad practice. An officer said that since Mr Clacher's death, staff had been reminded to check on prisoners at unlock as they are trained to do. Nevertheless, we make the following recommendation:

The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

ACCT procedures

88. It is a mandatory requirement under Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), that ACCT reviews must be multi-disciplinary where possible and consider and record progress against the initial caremap and the prisoner's general well-being. ACCT plans must only be closed once all the actions on the caremap have been completed.

89. Mr Clacher was already subject to ACCT procedures when he arrived at Guys Marsh. He had two outstanding caremap actions: to complete his methadone detoxification (which he had done) and to see the mental health team about his request for antipsychotic medication. There is no evidence on the ACCT record that Mr Clacher's caremap actions were reviewed on 16 March, although the nurse manager, chased an outstanding mental health referral from his initial health assessment.

90. On 19 March, a CM tried to get a mental health nurse to attend the review but they were busy. In their absence, he received assurance by telephone that Mr Clacher had an ongoing referral for a mental health assessment. He marked both outstanding actions complete and closed the ACCT plan. We do not consider that by its nature an ongoing process can be complete. Neither do we consider that a referral resolved the particular issue for Mr Clacher. The ACCT should not have been closed until Mr Clacher had been assessed by the mental health team.

91. Mr Clacher had a number of risk factors associated with suicide and self-harm but we do not consider that there was any obvious reason to believe his risk was heightened on 19 March. Although other prisoners subsequently told staff that Mr Clacher was being bullied over drug-related debts, we cannot say if this was the case. Mr Clacher did not mention it at his ACCT reviews at Guys Marsh (although he had spoken about it at Bullingdon some months earlier) and staff were not aware that he was using PS until 21 March.

92. In response to Mr Clacher's death, Guys Marsh reviewed their ACCT procedures and brought in new measures to ensure consistency of case management and facilitate multi-disciplinary case reviews. We make the following recommendation:

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

- **ACCT caremaps should have specific, meaningful actions aimed at reducing prisoners' risk to themselves and progress should be considered and documented at each review.**
- **All caremap actions have been completed before ACCT monitoring is stopped.**

The Emergency Response

93. PSI 03/2013 requires governors to have a two code medical emergency response system based on the instruction. As is usual, Guys Marsh use code blue to indicate an emergency when a prisoner is unconscious or having breathing difficulties, and code red when a prisoner is bleeding. Its provisions are mirrored in local policies at Guys Marsh. Calling an emergency code should automatically trigger the control room to call an ambulance.

94. Overall, the emergency response was very good. However, the control room officer did not call an ambulance immediately in response to the code blue but only after a CM instructed them to do so three minutes later. We are satisfied that there was no delay in providing emergency aid to Mr Clacher and it is therefore unlikely that the short delay in calling the ambulance affected the outcome for him.

95. We recently recommended that the Governor remind staff of the need to use an emergency code and we are aware that guidance to staff was issued in August 2018. In addition, emergency equipment was put on every unit and the prison has trained all custodial managers in Custodial Officer Immediate Life Support (COILS). We therefore make no recommendation.

Use of body-worn cameras in life saving medical intervention

96. PSI 04/2017 requires all staff attending any incident to turn on their body-worn camera. When a prisoner is receiving lifesaving medical intervention, the PSI requires staff to make a dynamic risk assessment and, if there is no threat to the security or safety of others, they should consider non-intrusive recording of the medical intervention such as directing the camera lens at the head and shoulders of the staff involved with occasional direct capture of the medical procedure.

97. In line with these instructions, a CM recorded the attempt to resuscitate Mr Clacher. Mr Clacher is in full view at all times and every aspect of the resuscitation attempt is visible. The CM said that he believed he had discretion whether to record events or not and did so because of the seriousness of it.

98. We do not criticise the CM who made a quick decision in difficult and stressful circumstances and who was part of the efficient and competent response to finding Mr Clacher hanged. Use of BWCs is relatively new in prisons and the guidance will take some time to be embedded in practice. In such situations it is most likely that staff will concentrate on trying to save a life rather than spend time deciding how to record the incident and we think this is right. However, we recognise that there must be a balance between capturing direct evidence of what happened and sensitivity and respect towards the prisoner and their family. We make the following recommendation:

    The Governor reminds staff of the guidance in PSI 04/2017 about the unobtrusive use of body worn cameras in lifesaving medical intervention.

Prisons &
Probation
Ombudsman
Independent Investigations

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

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

T I 020 7633 4100
F I 020 7633 4141