

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Paul Cavner, a prisoner at HMP Northumberland, on 1 November 2020

**A report by the Prisons and Probation Ombudsman**

## 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](https://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 Paul Cavner died on 1 November 2020, after he was found hanging in his cell at HMP Northumberland. He was 56 years old. I offer my condolences to Mr Cavner's family and friends.

Staff started suicide and self-harm procedures (known as ACCT) for Mr Cavner on 16 October 2020, after he told them that he had taken an overdose of his prescribed medication because he was hearing voices. ACCT monitoring was stopped on 26 October. Six days later, Mr Cavner was found hanging in his cell.

I am concerned that staff stopped ACCT monitoring prematurely. Not only had a mental health assessment not been carried out when the decision to stop monitoring was made, but no one from the mental health team had input to the decision.

There was also a lack of continuity in staff attendance at the ACCT case reviews and ACCT documentation was inaccurate as it showed that staff had made contributions when they had not done so.

At the start of ACCT monitoring, a mental health nurse arranged a urine test to check whether Mr Cavner's confusion was caused by a urinary tract infection (UTI). The mental health team agreed that they would decide next steps once they had ruled out a UTI. However, even though the test results (which were clear) were uploaded to the electronic medical record, the mental health team were not notified. It is likely that Mr Cavner would have had a mental health assessment had the mental health team been aware of the urine test result.

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**

**August 2021**

## **Contents**

Summary .....	1
The Investigation_Process .....	3
Background Information .....	4
Key Events .....	6
Findings.....	111

# Summary

## Events

1. In May 2019, Mr Paul Cavner was remanded in prison custody, charged with sexual offences. In September, he was convicted and sentenced to nine years in prison. In October, he was moved to HMP Northumberland.
2. Mr Cavner had reduced mobility because of a stroke in 2007 and used a wheelchair and walking sticks to move around. He had no other significant physical issues and there were no concerns about his mental health.
3. On 16 October 2020, Mr Cavner told staff that he had taken an overdose of his prescribed medication because he was hearing voices. He was taken to hospital but discharged the same day. Staff started suicide and self-harm procedures (known as ACCT).
4. On 19 October, at the second ACCT case review, a mental health nurse noted that Mr Cavner appeared very confused. She arranged a urine test to see whether a urinary tract infection (UTI) might be causing his delusions. On 21 October, she noted that the mental health team would await the urine test result before deciding whether to do a full mental health assessment.
5. On 26 October, the urine test results came back clear but the mental health nurse was not notified, and she forgot to check for them.
6. On the same day, a supervising officer chaired the third ACCT review and decided to stop ACCT monitoring. The mental health nurse was not at the review and had no input to the decision.
7. On the afternoon of 1 November, a PCO (Prison Custody Officer) unlocked Mr Cavner for his medication and found him hanging in his cell. He cut the ligature and started cardiopulmonary resuscitation (CPR). Healthcare and other staff attended and assisted. Paramedics arrived and also administered life support but declared Mr Cavner dead shortly afterwards.

## Findings

8. We consider that staff stopped ACCT monitoring prematurely on 26 October. Although Mr Cavner had not had a mental health assessment, the case manager marked this caremap action as complete and closed the ACCT. The mental health nurse who had attended the second case review and said she would carry out a mental health assessment once she had ruled out a UTI, was not invited to the case review and had no input to the decision to stop ACCT monitoring.
9. There was a lack of continuity in staff attendance at ACCT reviews. We also found that the ACCT documentation was inaccurate as it listed staff as having contributed to case reviews when they had not done so.
10. The results of the urine test (which were clear) were uploaded to the electronic medical record on 26 October, but the system does not trigger an alert when results are uploaded so the mental health nurse who had asked for the test was unaware. She said that if she had been invited to the case review that day, it

would have prompted her to check for the results, but she was not invited to the review so forgot to do so. It is likely that Mr Cavner would have had a mental health assessment if the mental health team had been told that his urine test result showed that he did not have a UTI.

## Recommendations

- The Director should ensure that staff manage prisoners at risk of suicide and self-harm in line with national policy, in particular staff should:
  - ensure there is a consistent case manager wherever possible;
  - hold multidisciplinary case reviews, ensure a member of healthcare staff attends the first case review and try to ensure continuity of staff attendance at case reviews where possible;
  - record accurately who attended and contributed to case reviews and the contributions made;
  - assess risk based on the prisoner's known risk factors and not solely on what the prisoner tells them; and
  - close an ACCT only once all caremap actions have been completed.
  
- The Head of Healthcare should review the process for requesting physical investigations and develop a protocol to ensure all staff who need to be informed are included in the reporting process.
  
- The Director should share this report with SPCOs A and B and ensure that a senior manager discusses the Ombudsman's findings with them.

## The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Northumberland informing them of the investigation and asking anyone with relevant information to contact her.
12. The investigator obtained copies of relevant extracts from Mr Cavner's prison and medical records.
13. The investigator interviewed 13 members of staff. NHS England commissioned a clinical reviewer to review Mr Cavner's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff. All the interviews were conducted by telephone because of the COVID-19 pandemic restrictions.
14. We informed HM Coroner for Northumberland of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Cavner's next of kin to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked why staff had stopped checks on Mr Cavner. This is covered in the report.
16. Mr Cavner's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.
17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and some amendments have been made to this report.

## Background Information

### HMP Northumberland

18. HMP Northumberland is a Category C prison which holds up to 1,368 men. Sodexo Justice Services manage the prison and Spectrum provides healthcare services. Healthcare staff are on duty from 7.30am to 7.30pm from Monday to Thursday and from 7.30am to 6.00pm on Friday. At weekends and on Bank Holidays, healthcare staff are on duty from 8.00am to 6.00pm. Northern Doctors Urgent Care provide an out of hours service at other times. Tees, Esk and Wear Valley Mental Health NHS Foundation Trust provides mental health services.

### HM Inspectorate of Prisons

19. The last full inspection of HMP Northumberland was in August 2017. Inspectors found that mental health services were provided effectively at the prison but the management of prisoners subject to suicide and self-harm prevention procedures (known as ACCT) was weak, reviews were poorly attended and caremaps were incomplete. Handover arrangements were also poor and required observations did not always take place. Access to Listeners (prisoners trained by the Samaritans to provide support to other prisoners) was inadequate, although it was better for prisoners on the vulnerable prisoner unit.
20. HMIP carried out a scrutiny visit at Northumberland in September 2020 to look at the treatment of prisoners during the COVID-19 pandemic. In its survey, 60% of those who had been monitored under ACCT reported feeling cared for by staff. Inspectors reported that from their review of ACCT documentation, initial assessments were generally good, and case reviews were mostly multidisciplinary with input from the mental health team. However, they found several cases where ACCT documents had been closed soon after incidents of self-harm had taken place, which raised questions about whether risk was being well managed in those instances.
21. Inspectors reported that mental health services were responsive and providing face-to-face support, including access to psychological therapies. The team were attending all initial ACCT reviews and prisoners had direct access to them using their in-cell telephones.

### Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 December 2019, the IMB reported that ACCT records were closely monitored by Safer Custody and Board members considered they were usually of a good standard. Staff were frequently reminded of the signs to look for to identify prisoners who may need extra support.

### Previous deaths at HMP Northumberland

23. Mr Caver's was the fifth death at Northumberland since November 2018. One previous death was also self-inflicted and the other three were from natural

causes. There are no similarities between the recommendations made in those cases and Mr Cavner's.

### **Assessment, Care in Custody and Teamwork**

24. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. 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 the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

## Key Events

25. On 31 May 2019, Mr Paul Cavner was remanded in prison custody, charged with sexual offences, and sent to HMP Durham. On 23 September, he was convicted and sentenced to nine years in prison.
26. On 18 October, he was moved to HMP Northumberland where he was located on a houseblock for older prisoners from December 2019 onwards.
27. Mr Cavner had reduced mobility following a stroke in 2007. On 18 March 2020, Mr Cavner was given a wheelchair and he also used sticks to walk with. Apart from this, he had no significant physical healthcare issues and there were no concerns about his mental health.

### ACCT: 16-26 October 2020

28. On 16 October, at approximately 10.05am, a Prison Custody Officer (PCO) unlocked Mr Cavner's cell. Mr Cavner told him he had taken 80 sodium bicarbonate (antacid) tablets, 15 atenelol tablets (prescribed for high blood pressure) and 16 paracetamol tablets. He said he had done this because people were shouting at him at night and watching him through the air vents. The PCO took Mr Cavner to the healthcare unit, where healthcare staff said that Mr Cavner should be taken to hospital. The PCO started suicide and self-harm prevention procedures (known as ACCT).
29. Senior Prison Custody Officer (SPCO) A completed the Immediate Action Plan and set observations at two an hour while in the prison and one an hour while in hospital. She also set conversations with Mr Cavner at four a day.
30. Mr Cavner was taken to hospital but was discharged the same day.
31. A PCO carried out the ACCT assessment interview while on escort duties at the hospital. She recorded that Mr Cavner said that he heard voices saying unpleasant things to him and that on this occasion, it had got him down and he had acted on impulse. He said had been feeling low for about two months. He said it was the first time he had self-harmed. Mr Cavner engaged well with her and said he was in contact with his sister and had friends on the wing. He said he had wanted 'to end it all' but not to the extent he wanted to be dead – he had meant he wanted to end the voices telling him to take his medication. Mr Cavner agreed to engage with mental health staff and the ACCT process and to maintain contact with friends. He also said he would speak to staff if he was feeling low.

### *1<sup>st</sup> case review*

32. On 17 October, SPCO A held the first case review at 8.30am. She noted that a PCO and a nurse contributed to the review (either in person or gave an oral contribution). When interviewed, the PCO said she definitely did not attend the review and was not asked for a contribution; the nurse could not recall attending or giving a contribution either. SPCO A recorded on the case review record that the nurse's contribution was that Mr Cavner was not known to healthcare, apart from the overdose incident, and that they had no concerns.

33. SPCO A noted that no mental health nurses were available at the weekend and she would hold another case review on the Monday morning with one present. She also noted that Mr Cavner was in good spirits, made good eye contact and engaged well. He talked about various voices which he believed came through the air vent telling him what to do and became tearful when she asked him when the voices had started, implying they might be another prisoner. She explained to him why this could not be the case. She recorded that he had been moved to another cell because of this (although, to date, the prison have not been able to confirm either the date or reason for the move).
34. Mr Cavner said that he would speak to his sister that weekend about how he was feeling and that he regretted his actions the previous day. SPCO A assessed his risk as low and scheduled the next case review for 19 October.
35. The caremap listed the following issues and actions: voices in head – speak to the mental health team; medication in possession – speak to healthcare; have appointment with the mental health team to be assessed; and a medication review.

#### *2<sup>nd</sup> case review*

36. On 19 October, SPCO A held the second case review. Mr Cavner and a mental health nurse attended. Mr Cavner was shaking and upset and said people had been shouting at him and telling him he was going to be moved to another houseblock. He was wearing multiple layers of clothes in anticipation of the move.
37. Mr Cavner told the nurse the voices he heard were unpleasant and abusive, and said he had trouble remembering things after being beaten up in 2007. The nurse said she would do a full mental health assessment later that week and would also arrange for a urine test to rule out a urinary tract infection (UTI) being the cause of Mr Cavner's confusion. She sent a task for nurses to take a urine sample that day.
38. SPCO A reduced observations to one in the morning, afternoon and evening and four during the night. She set one quality conversation a day. She told the investigator that she wanted to keep the ACCT open until a full mental health assessment had been done, but she was satisfied that Mr Cavner's regret about the overdose lowered his risk and he assured her he had friends on the wing he could speak to.
39. SPCO A signed off the first two caremap actions - to speak to healthcare staff at the next review about medication in possession and to speak to the mental health team at the next review – as having been completed. Mr Cavner was no longer receiving his medication in possession and the mental health nurse said she would arrange the mental health assessment appointment when she had more information. SPCO A scheduled the next case review for 26 October.
40. A PCO held a key worker session with Mr Cavner by telephone on 19 October as he was on an ACCT. (Mr Cavner had had key worker sessions approximately weekly since arriving at Northumberland, and in March 2020 they were replaced with weekly telephone welfare checks for most prisoners during the COVID-19

pandemic. However, key working sessions continued during the pandemic for those who were considered a priority, including prisoners on ACCTs).

41. The PCO noted that Mr Cavner was 'slightly withdrawn' but he said he was doing 'alright'. He told her about his overdose and that his medication had been taken off him (although a meeting was due to sort this out). He told her he found the restricted COVID regime difficult, but he was keeping occupied by watching TV when he was locked in his cell and playing cards with other residents when he was allowed out. She talked about the additional services that were available during the lockdown and advised him to use his extra phone call credit to speak to his sister.
42. This was the last key worker session Mr Cavner had because his ACCT was closed before the next session was due.
43. On 21 October, a mental health nurse noted that the primary mental health team had discussed Mr Cavner's case but decided to wait for the results of the urine test before deciding on the best course of action. She noticed the task for the urine test had not been actioned and re-sent it that day. The urine sample was taken and sent off for analysis on 22 October.
44. On 26 October, a prison GP noted that Mr Cavner's urine test was normal, and no further action was required. The mental health nurse was not notified, as there was no system in place for the person receiving the sample results to tell the requester they had arrived.

### *3<sup>rd</sup> case review*

45. On 26 October, SPCO B chaired the third ACCT review. He noted that a member of the mental health team did not attend but that a mental health support worker gave an oral contribution (although he did not record what this was). He also noted that a PCO attended. However, although the PCO gave SPCO B a contribution in person, he did not actually attend the review with Mr Cavner present. SPCO B did not record what the PCO's contribution was.
46. SPCO B noted that Mr Cavner explained he had been hearing voices which had encouraged him to take the tablets but since working with the mental health team he realised the voices were caused by stress. Mr Cavner said he was now 'coming to terms with the voices' and wanted to live to see his grandchildren and had 'absolutely no intention of self-harming or attempting suicide again'. SPCO B marked the caremap actions about the mental health appointment and the medication review as having been completed. He closed the ACCT and set a post-closure review for 2 November.

### **1 November 2020**

47. At approximately 9.00am on 1 November, PCO A unlocked prisoners who needed to get their medication. He told the investigator that Mr Cavner's complexion usually had a yellow tinge but that he looked particularly well that morning. He said he spoke briefly to Mr Cavner and had no concerns about him. SPCO A saw Mr Cavner at around 9.30am. She also thought he was looking very well and, when she asked him how he was, he said he was 'feeling great'.

48. Prisoners were given lunch in their room between 11.15am and 11.30am. We do not know who gave Mr Cavner his, but he was seen around this time by PCO B, who was doing the roll check at about 11.30am. PCO B told the investigator that Mr Cavner was standing in his room, aided by his walking stick, with his lunch on top of a tall cabinet. He thought it strange that Mr Cavner was not sitting down to eat his lunch, but he did not appear distressed and he did not speak to him.
49. Just before 3.40pm, PCO A went to Mr Cavner's cell to unlock him for his afternoon medication. He could not see Mr Cavner through the observation panel. He unlocked the cell door and found that the bed was partially obstructing the door, and Mr Cavner was lying face down underneath the bed. He called a code blue. Mr Cavner had one end of a blanket wrapped around his neck, with the other end of the blanket secured to the bed frame. PCO A cut the ligature and started cardiopulmonary resuscitation (CPR) and other staff arrived.
50. The control room log shows a code blue was called at 3.40pm and staff in the control room called an ambulance straightaway. At 3.43pm, while control room staff were still on the phone to the emergency services, information came through that Mr Cavner was receiving CPR. Control room staff relayed this to the emergency services operator who upgraded the ambulance to an '8-minute response' and it arrived at 3.51pm.
51. A nurse and a healthcare support worker responded and were at the scene within seconds. Another nurse arrived shortly afterwards. Mr Cavner had lacerations to his face, and his tongue was swollen. There was no sign of life, but he was still warm to touch.
52. The nurses continued CPR and applied a defibrillator (an electronic device that monitors the electrical activity from the heart and delivers a shock if required to attempt to stabilise the rhythm), but no shock was required.
53. Paramedics arrived and delivered advanced life support. However, they were unable to resuscitate Mr Cavner and declared his death at 4.21pm.

### **Contact with Mr Cavner's family**

54. The prison appointed a family liaison officer at 4.45pm. She telephoned Mr Cavner's next of kin that afternoon to break the news. The prison contributed to the funeral costs in line with national policy.

### **Support for prisoners and staff**

55. After Mr Cavner's death, the duty manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
56. The prison posted notices informing other prisoners of Mr Cavner'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 his death.

## **Post-mortem report**

57. The post-mortem report concluded that Mr Cavner died as a result of hanging. Toxicology tests showed no trace of alcohol and only therapeutic levels of his prescribed medication (atenolol and paracetamol).

# Findings

## Management of Mr Cavner's risk of suicide and self-harm

58. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, sets out the procedures (known as ACCT) that should be followed when a prisoner is identified as being at risk of suicide and self-harm.
59. Staff appropriately started ACCT procedures for Mr Cavner on 16 October 2020 after he took an overdose of his prescribed medication. However, we consider that the ACCT was closed prematurely on 26 October, six days before Mr Cavner hanged himself, and we are concerned that the ACCT process was not managed well.

### *Premature closure of ACCT on 26 October*

60. At the second ACCT case review on 19 October, a mental health nurse said that she would do a full mental health assessment later that week and also arrange for a urine test to rule out a urinary tract infection as the cause of Mr Cavner's confusion. She was expecting to be invited to the next ACCT review, by which time she would have the test result and would know whether Mr Cavner required a full mental health assessment or not.
61. At interview, SPCO B said that he had spoken to a mental health support worker on the phone and she had told him that the mental health nurse had seen Mr Cavner and that the mental health team had no concerns. He said he had assumed that the mental health support worker was a mental health nurse. The mental health support worker told the investigator she could not recall being asked to contribute to Mr Cavner's ACCT review and said that while she might have dealt with straightforward queries, such as confirming whether or not a prisoner was on the mental health caseload, she would always refer more complex queries to a mental health nurse.
62. As Mr Cavner's mental health was such a key issue in the assessment of his risk to himself, we consider that SPCO B should have ensured that the mental health nurse was invited to the third case review on 26 October, and should not have relied on a phone conversation with someone who had not previously been involved in the ACCT process. We also consider that SPCO B should have recorded what the mental health support worker said in the review paperwork.
63. Although SPCO B marked the caremap action for a mental health assessment as having been completed, Mr Cavner had not had a mental health assessment. At interview, SPCO B said that when the mental health support worker told him that the mental health nurse had seen Mr Cavner, he had assumed that this was for a mental health assessment, but he had since realised that she may have just meant an initial review.
64. We consider that it was a significant failing for there to have been no mental health nurse at the third case review and no input from them into the decision to close the ACCT. We consider that Mr Cavner should have had a mental health

assessment and a decision should have been made about what form of mental health support he needed before ACCT monitoring was stopped.

#### *Poor risk assessment*

65. We consider that both SPCOs A and B relied too heavily on what Mr Cavner said when they assessed his risk, and did not give sufficient weight to his risk factors: he had recently taken an overdose and he said he had done so because he was hearing voices.
66. At the first case review SPCO A assessed Mr Cavner's risk as 'low' because he was in 'good spirits' and said he regretted his actions. We consider that this was inappropriate given it was only the day after the overdose and Mr Cavner was still hearing the voices. At the final case review, SPCO B closed the ACCT on the basis that Mr Cavner said he wanted to live to see his grandchildren and had 'absolutely no intention of self-harming or attempting suicide again'.
67. We also consider that SPCOs A and B were not qualified to assess what hearing voices meant in terms of Mr Cavner's risk to himself without mental health input.

#### *Inconsistent case manager and attendance at case reviews*

68. SPCO A chaired the first two ACCT case reviews, but then SPCO B chaired the third one. SPCO B was not due to chair the case review as he was not responsible for the unit that Mr Cavner was on; he was covering for a colleague who was unexpectedly off work that day. SPCO B said that he had met Mr Cavner when he was on the induction unit but other than that, he had had no contact with him.
69. While we understand that it may not always be possible to have a consistent case manager, we consider that this case highlights the dangers of not doing so. SPCO B had very little knowledge about Mr Cavner and yet made the decision to close the ACCT.
70. It appears that SPCO B based this decision on Mr Cavner telling him that he had no intention of self-harming again, rather than an objective assessment of his risk factors and his current state of mental health. Where the case manager is not familiar with the prisoner, it makes it even more important to ensure that there is multidisciplinary input to ACCT reviews, from a range of staff who understand the prisoner's risks and needs.
71. PSI 64/2011 says that the ACCT process will operate more effectively if there is continuity in attendance of staff from relevant departments. It is particularly unfortunate in this case that the mental health nurse, who was familiar with Mr Cavner's issues, having attended the second case review and asked for the urine test, was not invited to the third case review when the decision to close the ACCT was made.

#### *Attendance at case reviews and inaccurate ACCT documentation*

72. PSI 64/2011 says that the first case review should be attended by the ACCT assessor whenever possible, a member of staff who knows the prisoner (for example, a wing officer) and a member of healthcare staff. It says that if invited

participants cannot attend in person, exceptionally, they can provide a written account of their input.

73. On 17 October 2020, SPCO A listed a nurse and a PCO as having contributed to the first case review. However, it is unclear whether either attended and there is no written record of their input. The nurse told the investigator she could not remember speaking to SPCO A and that she would always normally make an entry on SystmOne (electronic medical record) if she had done so. She also doubted that she would have said Mr Cavner was not known to healthcare apart from the overdose incident because he collected medication from them. The PCO told the investigator that she neither attended the case review nor gave a contribution – she had just carried out the initial assessment when she was with Mr Cavner at the hospital.
74. When interviewed, SPCO A was certain that she did speak to the nurse but accepted that she had named the PCO as making a contribution in error. She said she had only done her ACCT case manager training in August 2020 (with the rest due to be carried out once the COVID-19 situation allowed). She said she thought that because the PCO had carried out the assessment, that constituted a contribution to the case review.
75. At the third case review, SPCO B listed a PCO as having attended, when in fact he spoke to SPCO A outside the review meeting. In addition, he did not record what the PCO had said in the ACCT document.
76. At interview, SPCO B acknowledged it was an error to have recorded that the PCO had attended but said that the intention had been that he would. The plan had changed when another new officer wished to observe the ACCT and the SPCO considered there would be too many of them in one small room, so he decided to speak to the PCO separately on the wing instead. Again, he acknowledged it was an error to have not recorded the PCO's contribution on the ACCT document.
77. We recommend:

**The Director should ensure that staff manage prisoners at risk of suicide and self-harm in line with national policy, in particular staff should:**

- **ensure there is a consistent case manager wherever possible;**
- **hold multidisciplinary case reviews, ensure a member of healthcare staff attends the first case review and try to ensure continuity of staff attendance at case reviews where possible;**
- **record accurately who attended and contributed to case reviews and the contributions made;**
- **assess risk based on the prisoner's known risk factors and not solely on what the prisoner tells them; and**
- **close an ACCT only once all caremap actions have been completed.**

## Clinical care

78. The clinical reviewer found that initially Mr Cavner received responsive, proactive care from mental health services at Northumberland. He considered it appropriate that a urine test was requested as there could have been a physical cause for Mr Cavner's psychotic symptoms. The mental health nurse was initially proactive in ensuring that the urine test took place, but there was no system to ensure that she received the results.
79. The mental health nurse said that she had simply forgotten to check on the results and the system does not trigger an alert when test results are logged. (The acting Head of Healthcare confirmed that there was no system in place for individuals receiving test results to alert the person who had requested them.) The nurse said she had assumed she would be asked to the third case review and that would have acted as a prompt for her to look up the results and decide how to proceed with Mr Cavner. However, she was not invited to the third ACCT case review and the ACCT was closed. In addition, she had not arranged a follow up appointment to review Mr Cavner, which she said she had planned to do once the results were received. She accepted that this was an error on her part.
80. We recommend:
- The Head of Healthcare should review the process for requesting physical investigations and ensure a protocol is developed to ensure all staff who need to be informed are included in the reporting process.**

## Learning lessons

81. We consider it important that staff learn the lessons from the PPO's investigations. We therefore recommend:
- The Director should share this report with SPCOs A and B and ensure that a senior manager discusses the Ombudsman's findings with them.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations