Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Leon Upfold, a prisoner at HMP High Down, on 4 December 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 Leon Upfold was found hanging in his cell at HMP High Down on 29 November 2020 and died five days later in hospital. He was 45 years old. I offer my condolences to Mr Upfold's family and friends.

Mr Upfold had a history of mental health problems, substance misuse and self-harm. We are concerned that the nurse who saw him when he arrived at High Down on 21 November, did not read his medical records and did not refer him to the mental health team.

On 28 November, Mr Upfold self-harmed and staff appropriately began monitoring him under HMPPS suicide prevention measures, known as ACCT. However, they reduced the frequency of observations less than two hours later. We are concerned that they placed too much weight on Mr Upfold's presentation and assertions that he had no suicidal intentions and did not give sufficient weight to his risk factors, and that, as a result, they underestimated his risk.

We also share the clinical reviewer's concern that communication and information sharing between the primary healthcare team, the mental health in-reach team and the substance misuse team was not sufficiently collaborative.

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**

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Summary

Events

1. Mr Leon Upfold had a history of mental health problems, substance misuse and self-harm. On 21 November 2020, Mr Upfold was remanded in custody to HMP High Down on a charge of theft. He was started on an alcohol and heroin detox programme.

2. On the afternoon of 28 November, Mr Upfold cut his wrist with a plastic knife and said he was hearing voices. Staff began monitoring him hourly under Prison Service suicide prevention measures, known as ACCT. Following a case review around two hours later, it was agreed that Mr Upfold's observations should be reduced from hourly to three times daily and five times overnight.

3. At about 2.30pm on 29 November, an officer found Mr Upfold hanging in his cell. The officer immediately shouted for assistance and radioed a medical emergency 'code blue', indicating a life-threatening situation. The officer cut the ligature and began cardio-pulmonary resuscitation (CPR). Nurses responded quickly to the code blue and began efforts to save Mr Upfold's life.

4. At around 4.00pm, Mr Upfold was taken to hospital in an ambulance. He did not regain consciousness and died in hospital on 4 December.

Findings

Management of risk of suicide and self-harm

5. The nurse who saw Mr Upfold when he arrived at High Down did not read his medical record. She was not therefore aware that he had a history of mental ill health and self-harm and an outstanding psychiatric appointment from HMP Wandsworth. We consider that she should have referred him to the mental health team in the light of his history.

6. Staff appropriately started ACCT procedures when Mr Upfold self-harmed on 28 November. However, we are concerned that those present at the ACCT case review around two hours later gave too much weight to Mr Upfold's presentation and his assertions that he had no suicidal intentions when they decided to reduce the frequency of his observations. We do not consider that his risk factors – his history of self-harm and mental health issues and the fact that he was detoxing - were given adequate weight.

7. We are also concerned that a member of staff recorded on Mr Upfold's ACCT caremap that he had referred Mr Upfold to the mental health team, when there is no evidence that the referral was made.

Substance misuse

8. Mr Upfold had a long history of substance and alcohol misuse. Due to a misunderstanding, post-mortem toxicology tests were not completed. As a result, we cannot say if Mr Upfold had used illicit drugs or alcohol before he died.

9. The clinical reviewer found that Mr Upfold's mental health and substance misuse issues were interlinked. We share her concern that communication and information sharing between primary healthcare teams, mental health in-reach services and substance misuse teams was not sufficiently collaborative.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff conducting reception health screens:

    - take into account all relevant information, including a prisoner's clinical history, referrals or contact with mental health services and relevant prison documentation, to assess his risk factors for suicide and self-harm and his mental health needs; and

    - refer prisoners for a mental health assessment whenever they have a serious history of self-harm or an outstanding psychiatric assessment.

- The Head of Healthcare should ensure that a copy of this report is shared with Nurse A, and that a senior manager discusses the Ombudsman's findings with her.

- The Governor should ensure that all staff assessing a prisoner's risk take into account all relevant information, including a prisoner's self-harm history, and do not rely solely on what a prisoner says or how he presents.

- The Governor should ensure that a copy of this report is shared with SO A and Officer A and that a senior manager discusses the Ombudsman's findings with them.

- The Head of Healthcare and the Substance Misuse Team Manager should ensure joint management of care planning to meet prisoners' holistic mental health, physical health and substance misuse needs.

The Investigation Process

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

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

12. The investigator interviewed 14 members of staff at High Down. The interviews were completed by video link and telephone due to the restrictions imposed as a result of the COVID-19 pandemic.

13. NHS England commissioned a clinical reviewer to review Mr Upfold's clinical care at the prison. The majority of the interviews were conducted jointly by the clinical reviewer and the investigator.

14. We informed HM Coroner for Surrey of the investigation. The coroner provided us with a copy of the post-mortem report. We have sent the coroner a copy of this report.

15. We contacted Mr Upfold's next of kin to explain the investigation and to ask if he had any issues that he wanted the investigation to consider. Mr Upfold's son received a copy of the draft report. He did not make any comments.

16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not identify any factual inaccuracies.

Background Information

HMP High Down

17. HMP High Down is a local prison in Surrey, which holds up to 1,150 men. Central and North-West London (CNWL) NHS Foundation Trust provides primary health services and in-reach mental health care. Anchor Health delivers GP services. The healthcare unit has inpatient facilities with 24-hour nursing cover. Substance misuse services are provided by the Forward Trust.

HM Inspectorate of Prisons

18. The most recent full inspection of HMP High Down was in May 2018. Inspectors reported that drugs were easily available. They were particularly concerned about the prevalence of psychoactive substances (PS). Governance and partnership arrangements for healthcare were good. Demands for mental healthcare were high but services were good. Inspectors found that nurses and prison officers in the healthcare unit worked collaboratively to deliver respectful care.

Independent Monitoring Board

19. 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 December 2019, the IMB reported that prisoners said that drugs were easily available in the prison. There had been a 68% increase in reported drug finds.

Previous deaths at HMP High Down

20. Mr Upfold was the fourth prisoner at High Down to die in the last two years. Of the previous three deaths, two were self-inflicted and one was from natural causes. We found that the prisoner's risk factors were not properly assessed in reception in one of the previous self-inflicted deaths. The other is still being investigated by the Ombudsman.

21. There have been three more deaths at High Down since Mr Upfold died, all from natural causes.

Assessment, Care in Custody and Teamwork

22. 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 irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

23. 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. 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

Background

24. Mr Leon Upfold first served a custodial sentence in 1994, when he was 18 years old. He served several further custodial sentences for offences including assault, burglary and theft.

25. Mr Upfold had a history of mental health problems, self-harm and substance misuse. He was assessed as being at risk of suicide and self-harm several times while in prison, and was monitored under Prison Service suicide prevention measures, known as ACCT. While at HMP High Down in January 2016, Mr Upfold was found by officers with a ligature around his neck. His medical records contain frequent references to his alcohol and substance misuse (cannabis, cocaine, crack cocaine and heroin). He was prescribed olanzapine (an anti-psychotic) and amitriptyline (an antidepressant) intermittently while in prison, the last time being in December 2019.

26. On 3 August 2020, while a prisoner in HMP Wandsworth, Mr Upfold (who had not been taking olanzapine for several months because he had been using illicit drugs) reported that he had been hearing voices and muffling noises. He was added to the list to be seen by the psychiatrist. However, he was not seen before his release from Wandsworth on 4 September.

HMP High Down

27. On 21 November 2020, Mr Upfold was remanded in custody to High Down after being charged with theft. His Person Escort Record (PER), a document that travels with prisoners between police, court and prisons, indicated that he was not at risk of suicide or self-harm, but noted under 'other risk information': "Yes – has been sectioned for drug induced psychosis years ago, no signs of it at the moment PNC (Police National Computer) for bipolar".

28. An officer carried out Mr Upfold's first night in custody interview. Mr Upfold told the officer that he had no thoughts of suicide or self-harm. The officer gave Mr Upfold a vape kit and two capsules and recorded on the prison's information management system (NOMIS) that he maintained good eye contact and body language during the interview.

29. During an initial health screen, Mr Upfold told Nurse A that he had no thoughts of suicide or self-harm, no history of mental illness, and that he had not tried to harm himself either in prison or in the community. At interview, the nurse told us that she did not look at Mr Upfold's medical history to check his answers. She recorded on Mr Upfold's medical record (SystmOne) that she had no concerns about his current mental wellbeing. She referred Mr Upfold to the substance misuse team.

30. Mr Upfold was then assessed by a substance misuse specialist. The specialist recorded on SystmOne that Mr Upfold said he smoked £30 of heroin and £200 of crack cocaine a day in the community, and drank 20-30 cans of lager a day, plus cider and vodka. She noted that he had tested positive for opiates, cocaine and cannabinoids.

31. Mr Upfold told the substance misuse specialist that he had previously been prescribed olanzapine and amitriptyline, and that he had a history of drug-induced psychosis. She told us in interview that Mr Upfold was not presenting as mentally unstable, psychotic or depressed, so she did not have any concerns about his mental health. She prescribed methadone (a heroin substitute) for his heroin dependence. She also prescribed him various medications for alcohol withdrawal.

32. While in reception, a specialist substance misuse nurse met Mr Upfold to discuss his impending heroin, cocaine and alcohol detox. The nurse recorded on SystmOne that Mr Upfold presented with "obvious opiate withdrawal symptoms".

33. Due to the COVID-19 pandemic, Mr Upfold was taken to a cell on the Reverse Cohorting Unit (RCU), where he was to remain isolated from the main prison population for up to 14 days. He shared a cell with Prisoner A.

34. In line with the Forward Trust's drug treatment policy, staff closely monitored Mr Upfold's drug and alcohol withdrawal, including daily assessments on his progress, behaviour and presentation. On 23 November, Mr Upfold was prescribed various medications for his withdrawal symptoms. His methadone prescription was also increased to 20mls.

35. On 26 November, Prisoner A told a substance misuse nurse that Mr Upfold had been splashing himself with water to make it look like he was withdrawing. He was concerned that an increase in Mr Upfold's methadone dose could make him worse because Prisoner A had not taken methadone before. The nurse recorded the conversation in Mr Upfold's medical record and told a doctor.

28 November

36. At approximately 2.15pm, an officer opened an ACCT for Mr Upfold after he cut his wrist with a plastic knife. Mr Upfold told her he had cut his arm because he was distressed that the electricity in his cell was not working and he needed the TV to "drown out the voices". She placed Mr Upfold on hourly observations until he could be assessed further. Mr Upfold's wound was treated by a mental health nurse.

37. At around 3.30pm, Officer A (the duty ACCT assessor) conducted Mr Upfold's ACCT assessment interview. She recorded that Mr Upfold's relationship with his wife had broken down three years previously (which he said had led to him taking drugs and drinking alcohol to excess), that he had tried to hang himself when she left him, and that he was hearing voices and awaiting medication for this. Mr Upfold cited a lack of vapes and a difficult detox as factors in his decision to self-harm. She recorded that Mr Upfold was "quite low and fragile mentally and physically".

38. Officer A also recorded that Mr Upfold said he did "not wish to be dead" and that he was hopeful he could reconnect with his children after kicking his drug and alcohol habits. She recorded the key issues as: 'vapes', 'help with drug and alcohol issues' and 'help with hearing voices'.

39. At around 3.55pm, Mr Upfold's ACCT case review took place. It was chaired by Supervising Officer (SO) A and attended by Mr Upfold, a nurse from the mental health team and Officer A.

40. SO A recorded that Mr Upfold said he had harmed himself because he was not getting medication for his mental health, and the lack of electricity in his cell meant that he could not use the TV to drown out the voices in his head. Mr Upfold also told the SO that someone had stolen his vape capsules when he was in reception. The SO explained to Mr Upfold that he would be referring him to the mental health team, but that he had to be steady on his detox before they could work with him.

41. SO A recorded that Mr Upfold said he felt stupid for self-harming, that he wished he had spoken to someone first and that he would talk to staff in future. The SO also recorded that Mr Upfold got on well with his cellmate. He recorded Mr Upfold's level of risk as 'raised' and the panel agreed to reduce his observations from hourly to three daily and five overnight. (The SO told us at interview that he made a mistake and meant to record Mr Upfold's level of risk as 'low'.)

42. The ACCT panel agreed three issues for action on Mr Upfold's caremap: to restore the electricity in Mr Upfold's cell (which was done that afternoon); to refer Mr Upfold to the mental health team (the status of this action was recorded as "waiting for response"); and for Mr Upfold to engage with the Forward Trust to address his drug and alcohol issues (which he was doing already). In interview, SO A told us that he sent an email referral to the mental health team for Mr Upfold. However, we found no evidence that an email was sent. The SO also told us that he would have asked the mental health nurse to submit a referral, however there is nothing on SystmOne to show that this was either requested or actioned. Mr Upfold's next ACCT review was scheduled for 4 December.

43. Officers checked Mr Upfold at 5.00pm and 7.00pm and raised no concerns.

29 November

44. Officers completed ACCT checks on Mr Upfold five times during the night on 28-29 November and during the early morning roll check and raised no concerns.

45. At 9.00am, an officer let Mr Upfold out of his cell to see the substance misuse team and receive his medications and recorded on the ACCT ongoing record that Mr Upfold was "in good spirits".

46. A substance misuse worker saw Mr Upfold shortly before 9.30am. She recorded on SystmOne that Mr Upfold asked for an increase in his methadone prescription, saying that he was not stable on 20mls. She told him he would be monitored over the next 72 hours. She noted that Mr Upfold appeared very tired and lethargic and she advised him to drink plenty of fluids. She told us that although she did not mention it in her SystmOne entry, she was aware that Mr Upfold had self-harmed the previous day.

47. At 10.41am, an officer recorded on Mr Upfold's ACCT ongoing record that he told her he was feeling better and calmer because he now had a television. At 10.45am, according to his phone record, Mr Upfold tried to call his sister, but the call did not connect as he had no credit.

48. Officers checked Mr Uphold at around 12.40pm and raised no concerns.

49. At approximately 1.57pm, an officer unlocked Mr Upfold's cell and asked Mr Upfold and his cellmate if they wanted to go out for exercise. Prisoner A accepted the offer, but Mr Upfold did not want to. The officer left the cell door open to let Prisoner A out. Mr Upfold briefly left the cell but returned about two minutes later and the officer locked the door behind him. The officer told us in interview that Mr Upfold was lying on his bed when he left him.

50. At 2.32pm, Prisoner A returned from exercise, walked towards his cell and looked through the observation panel. In interview, the prisoner told us that he could not see properly because the cell was "blacked out". He walked back to the officer, who was a few cells down. The two of them then returned to the cell and the officer unlocked it. When they went into the cell, they found Mr Upfold hanging from a ligature made from a piece of material attached to a wooden frame on the wall.

51. The officer immediately radioed a medical emergency 'code blue', indicating a life-threatening situation. He cut the ligature and, with Prisoner A's help, managed to lay Mr Upfold on the floor. He could not find a pulse, so he began cardio-pulmonary resuscitation (CPR). The control room officer called an ambulance straight away following the code blue call. Officers and nurses arrived at the cell seconds later and supported resuscitation efforts.

52. At 2.51pm, ambulance staff arrived at the cell in full Personal Protective Equipment (PPE). At approximately 3.00pm, they found a pulse. At around 4.00pm, Mr Upfold was taken to St George's Hospital in Tooting by ambulance.

53. Mr Upfold never regained consciousness. On 4 December, a decision was taken to turn off Mr Upfold's life support in hospital. He was pronounced dead at 1.32pm.

Contact with Mr Upfold's family

54. The prison did not have a telephone number for Mr Upfold's nominated next of kin, but a senior manager located a contact number for Mr Upfold's ex-partner and rang her at approximately 5.00pm on 29 November. She advised him to speak to Mr Upfold's son and provided his contact details. He phoned Mr Upfold's son at approximately 5.15pm, told him what had happened and that his father had been taken to hospital.

55. The prison's Head of Security phoned Mr Upfold's son later that evening to introduce herself as the prison's Family Liaison Officer (FLO) and passed on her contact details.

56. The FLO stayed in touch with Mr Upfold's son and went to the hospital to meet family members on 2 December. Mr Upfold's family visited him in hospital for the final time on 4 December shortly before his life support was turned off. In line with national instructions, the prison offered to contribute to the costs of the funeral.

Support for prisoners and staff

57. A manager held a ‘cold debrief’ with prison staff involved in the emergency response at 10.00am the following day (30 November). All staff and prisoners were offered the support of the prison’s care team.

Post-mortem report

58. A post-mortem examination found that, on the balance of probability, Mr Upfold’s death was due to hypoxic brain injury (restricted flow of oxygen to the brain) due to hanging.

59. Due to a misunderstanding regarding the retention and collection of blood and urine samples, post-mortem toxicology tests were not completed. As a result, it is not possible to say if Mr Upfold had used illicit drugs and/or alcohol before he died.

Findings

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

Reception screen

60. Prison Service Instruction 7/2015 (covering early days in custody) says that staff should examine all newly arrived prisoners on their arrival and share, review and act on information, including past medical history, where necessary.

61. The National Institute for Health and Care Excellence (NICE) guidelines require that healthcare professionals should refer any new prisoner for a mental health assessment if they have tried to harm themselves in the past.

62. Given Mr Upfold's history of self-harm in 2016, his history of mental health issues and his outstanding referral for a psychiatric appointment from HMP Wandsworth in August 2020, we would have expected Nurse A, the reception nurse at High Down, to have referred Mr Upfold to the mental health team in line with NICE guidelines. However, in interview, she said that she had not reviewed Mr Upfold's past medical history on SystmOne during his initial health screen, and that she would not usually look at a prisoner's previous clinical history. Instead, she said she based her decision not to refer Mr Upfold on the answers he gave and the way he presented.

63. We share the clinical reviewer's concern that Nurse A did not review Mr Upfold's clinical history on SystmOne. We are very concerned that she relied on his presentation and did not check whether what he told her was true (which it was not).

64. We make the following recommendations:

    The Governor and Head of Healthcare should ensure that all staff conducting reception health screens:

    - **take into account all relevant information, including a prisoner's clinical history, referrals or contact with mental health services and relevant prison documentation, to assess his risk factors for suicide and self-harm and his mental health needs; and**

    - **refer prisoners for a mental health assessment whenever they have a history of self-harm or an outstanding psychiatric assessment.**

    The Head of Healthcare should ensure that a copy of this report is shared with Nurse A, and that a senior manager discusses the Ombudsman's findings with her.

ACCT

65. 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 staff must follow when they identify that a prisoner is at

risk of suicide and self-harm. It lists risk factors and potential triggers for suicide and self-harm.

66. An officer appropriately started ACCT procedures when Mr Upfold cut his wrist with a plastic knife on 28 November and he was placed on hourly observations. The ACCT assessor, Officer A, recorded that Mr Upfold had a number of risk factors: he had just cut his wrist, he had tried to hang himself three years earlier, he had substance misuse issues, he was having a difficult detox, and he said he was hearing voices.

67. At the first ACCT case review 25 minutes later, Mr Upfold's level of risk was assessed as 'low' (although incorrectly recorded as 'raised') and his observations were reduced from hourly to three during the day and five overnight. We note that after her ACCT assessment, Officer A recorded that Mr Upfold was "quite low and fragile mentally and physically". However, she told us at interview that he appeared "not upbeat, but … fine" at the case review,

68. We are concerned that staff at the case review did not give sufficient weight to Mr Upfold's risk factors and placed too much emphasis on his calm, polite behaviour and his assertions that he had no suicidal intentions. While the judgement of staff based on a prisoner's apparent mood and state of mind is important, prisoners will often try to hide their distress, particularly in a strange setting and with people they do not know. Assessments based on a prisoner's presentation must, therefore, be balanced against the available information about known risk factors.

69. We have said this repeatedly in our investigation reports over several years and it is disappointing to see the same failing in yet another case.

70. Given that one of Mr Uphold's risk factors was that he was having a difficult detox, we are also concerned that no one from the substance misuse team was present at the case review. We discuss this further below.

71. We are concerned that although SO A recorded on the caremap that he had referred Mr Upfold to the mental health team, there is no evidence that he did. Although it is unlikely that Mr Upfold would have been assessed before he died, this was an important omission.

72. We make the following recommendations:

The Governor should ensure that all staff assessing a prisoner's risk take into account all relevant information, including a prisoner's self-harm history, and do not rely solely on what a prisoner says or how he presents.

The Governor should ensure that a copy of this report is shared with SO A and Officer A, and that a senior manager discusses the Ombudsman's findings with them.

Substance misuse

73. Mr Upfold had a long history of substance and alcohol misuse, which is well-documented in his SystmOne records. When he arrived at High Down, he was treated for alcohol withdrawal and placed on a methadone programme. His

cellmate suggested that he was displaying drug-seeking behaviour by trying to exaggerate his withdrawal symptoms in order to be prescribed a higher dose of methadone. Mr Upfold attributed his self-harm on 28 November in part to a difficult detox.

74. Given the importance of substance misuse as a risk factor for Mr Upfold, we consider that SO A should have invited someone from the substance misuse team to the first ACCT case review. He told us at interview that he did not do so because at weekends they are “just doing meds”, although a substance misuse worker from the team told us that they would normally attend case reviews.

75. We are also concerned that Mr Upfold was told at the ACCT case review that he could not receive mental health intervention until his substance misuse needs were stabilised.

76. The clinical reviewer found that Mr Upfold’s mental health and substance misuse issues were interlinked. We share her concern that, communication and information sharing between the primary healthcare team, the mental health in-reach team and the substance misuse team should have been more collaborative.

77. We make the following recommendation:

The Head of Healthcare and the Substance Misuse Team Manager should ensure joint management of care planning to meet prisoners’ holistic mental health, physical health and substance misuse needs.

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