

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Maxfield a prisoner at HMP Stocken on 6 January 2019

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*



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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 Alan Maxfield died on 6 January 2019. He was found hanged in his cell at HMP Stocken. Mr Maxfield was 44 years old. I offer my condolences to his family and friends.

Mr Maxfield had a significant history of depression, and of suicide attempts and self-harm dating back to childhood. He was appropriately monitored under suicide and self-harm prevention procedures (known as ACCT) when he first arrived in prison in 2017 and again in August 2018, when he told a mental health support worker that he had a plan to kill himself.

I am concerned, however, that staff at Stocken did not use the ACCT process to support Mr Maxfield as effectively as they might have done because they focussed very narrowly on the prescription of antidepressant medication and did not consider what might have been the underlying reasons for Mr Maxfield's suicidal thoughts. I am also concerned that staff over-relied on Mr Maxfield's very positive demeanour and that, although staff appear to have talked to Mr Maxfield, there is no evidence that they had any meaningful conversations which might have encouraged him to share his distress.

Having said that, I recognise that Mr Maxfield appears to have been a private person and that he did not give staff or other prisoners reason to think he posed a risk to himself in the months before his death.

As in previous investigations at Stocken, we found failings in the emergency response when Mr Maxfield was found unresponsive in his cell. Although they did not affect the outcome for Mr Maxfield, who had been dead for some time when he was found, they could make the difference between life and death in other emergency situations. I am, therefore, escalating my concerns to the Prison Group Director for the North Midlands.

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 McAlister CB
Prisons and Probation Ombudsman

October 2019

Contents

Summary	1
The Investigation Process	4
Background Information	5
Key Events	8
Findings.....	15

Summary

Events

1. In January 2017, Mr Alan Maxfield was remanded to prison charged with false imprisonment and threats to kill his wife. He had a significant history of depression, suicide attempts and self-harm. This was his first time in prison. On arrival he said he was going to hang himself and was managed under suicide and self-harm prevention procedures (known as ACCT) for the first few weeks after which he seemed to settle into prison life.
2. In May 2017, he was sentenced to seven years imprisonment and was transferred to HMP Stocken. At Stocken, his behaviour was excellent. He became an 'enhanced prisoner' under the prison's privileges scheme, worked in the bicycle workshop and mentored other prisoners. Staff had no concerns about him.
3. He was taking antidepressants when he arrived at Stocken and the mental health team and a GP reviewed him regularly. In February 2018, Mr Maxfield asked healthcare staff to stop prescribing him antidepressants. A GP agreed to do so progressively but Mr Maxfield stopped taking his pills immediately. During the following months, officers continued to record positive comments about Mr Maxfield's behaviour at work and on the wing.
4. On 14 August, Mr Maxfield self-referred to the mental health team because his mental health had deteriorated. (He thought this was because he had stopped taking antidepressants.) He told the support worker that he had recurring suicidal thoughts and had devised a plan to kill himself (which he described).
5. The support worker immediately began ACCT monitoring for Mr Maxfield. She also arranged an urgent appointment with his GP, who re-prescribed him antidepressants. Staff closed the ACCT on 29 August because Mr Maxfield's said that he felt better with his medication and that he no longer wanted to kill himself.
6. During the following four months staff recorded no concerns about Mr Maxfield, who continued to behave well.
7. On the morning of 6 January 2019, a member of staff could not get a response from Mr Maxfield during a roll count. He telephoned a Custodial Manager who alerted other staff over his radio. At around 5.30am, an officer responded and saw that Mr Maxfield was suspended by a ligature. He radioed a medical emergency code, entered the cell and cut Mr Maxfield down. Staff started cardiopulmonary resuscitation procedures but stopped shortly afterwards as Mr Maxfield displayed clear signs of rigor mortis.
8. At around 6.16am, paramedics arrived at Mr Maxfield's cell and, at 6.17am, Mr Maxfield was pronounced dead.

Findings

Assessment and management of risk:

9. Mr Maxfield's risk factors for suicide and self-harm included a history of severe depression, a significant history of suicide attempts and self-harm, the violent nature of his offence against his wife and the breakdown in their relationship, and the fact that this was his first time in prison.
10. Staff initially managed Mr Maxfield's risk well. They made appropriate referrals to the mental health team and began ACCT monitoring when Mr Maxfield disclosed suicidal thoughts in August 2018.
11. However, we consider that the ACCT monitoring focused too narrowly on Mr Maxwell's medication issues, and did not give enough consideration to his underlying risk factors, which remained unchanged. This was a missed opportunity to encourage Mr Maxfield to discuss his feelings and to identify meaningful long-term actions to support him.
12. Following the ACCT's closure on 29 August, we accept that Mr Maxfield gave staff no indication that he continued to pose a risk to himself. However, although staff appear to have spoken to him regularly, we are concerned that there is no evidence that they had any meaningful conversations with him that might have given him the opportunity to share his concerns. This might have been different if Mr Maxfield had had a key worker, but he might still have chosen not to share his distress.

Mental health

13. The clinical reviewer found that some areas of the mental healthcare provided to Mr Maxfield at Stocken were not equivalent to what he would have received in the community. Mr Maxfield's mental health assessments were not carried out by a qualified mental health practitioner; he was not involved in drawing up his care plan; and he was discharged in error from the care of the mental health team for one month in October.
14. The clinical reviewer is satisfied that these failings did not contribute to Mr Maxfield's death and he commended the good work of the mental health support worker.

Emergency Response

15. We are concerned that the member of staff who found Mr Maxfield unresponsive on 6 January, did not act with any sense of urgency and did not use the radio system to call an emergency medical code. As a result, there was a significant and unacceptable delay of about 15 minutes before the medical emergency code was called. In addition, the code had to be called three times before the control room officer responded.
16. There was a further delay of 12 minutes in paramedics reaching Mr Maxfield's cell from the prison's gate.

17. Although these failings did not affect the outcome for Mr Maxfield (who appears to have been dead for some time when he was found), in other cases such delays could make the difference between life and death. We are concerned that this is the third investigation since January 2017 where we found deficiencies in the emergency response at Stocken.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular that they:
 - identify and consider all risk factors when assessing a prisoner's level of risk of self-harm and suicide;
 - adequately complete ACCT caremaps, taking appropriate actions to address known risk factors; and
 - work collaboratively with staff of all disciplines when assessing a prisoner's risk and making decisions on care planning.
- The Governor should ensure all prisoners have meaningful contact with identifiable officers who regularly check their wellbeing and record their contact in line with the prison's key officer scheme.
- The Head of Healthcare should provide the Ombudsman with evidence of what has been done to ensure that:
 - a qualified practitioner carries out mental health assessments;
 - there are no unjustified interruptions in service provision; and
 - all prisoners on the mental health caseload have a patient-centred care plan and risk assessment.
- The Governor should:
 - ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies so that there is no delay in calling a medical emergency code or calling an ambulance; and
 - review arrangements for paramedics' access to a prisoner to reduce avoidable delays.
- The Prison Group Director for the North Midlands should provide the Ombudsman with an account of the action he is taking to improve the response to medical emergencies at Stocken.
- The Governor and Head of Healthcare should ensure that a copy of this report is shared with the following members of staff so that they are aware of the Ombudsman's findings: Officer A; Officer B; Officer C; Officer D; Officer E; SO A; the CM; OSG A; OSG B; the mental health support worker; and the workshop instructor.

The Investigation Process

18. The investigator issued notices to staff and prisoners at HMP Stocken informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
19. The investigator obtained copies of relevant extracts from Mr Maxfield's prison and medical records.
20. The investigator interviewed nine members of staff and three prisoners at Stocken on 19 and 20 February 2019. He also interviewed one member of staff by telephone on 23 May 2019.
21. NHS England commissioned an independent clinical reviewer to review Mr Maxfield's clinical care at the prison. The clinical reviewer jointly conducted five interviews with the investigator.
22. We informed HM Coroner for Rutland and North Leicestershire area of the investigation. The coroner gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
23. One of the Ombudsman's family liaison officers contacted Mr Maxfield's father to explain the investigation and to ask whether he had any matters he wanted the investigation to consider. Mr Maxfield's father did not engage with the family liaison officer.
24. The prison service received a copy of the initial report. Their response to our recommendations and action plan is annexed to this report. They raise minor accuracy comments which we have addressed in this report.

Background Information

HMP Stocken

25. HMP Stocken is a medium security prison in Rutland which holds up to 853 men. Care UK provides healthcare services. Mental health services are sub-contracted to Northamptonshire Foundation NHS Trust. Inclusion – Midlands Partnership NHS Foundation Trust provides substance misuse services. The healthcare service operates from Monday to Friday from 7.30am to 6.30pm and from 8.00am to 5.30pm at weekends. Two GPs provide ten GP sessions per week.

HM Inspectorate of Prisons

26. The most recent inspection of HMP Stocken was carried out in February 2019. Inspectors reported that levels of self-harm had increased substantially since the previous inspection in 2015. They found serious deficiencies in ACCT management. Some caremaps did not include triggers and reviews were not always carried out when there had been a change in the prisoner's circumstances. Recorded interaction was poor. Inspectors found that there was good support for prisoners, however, including a counselling service and an adequate number of Listeners (prisoners trained by the Samaritans to assist their peers).
27. Inspectors found serious weaknesses in health care provision, with some poor practice evident in medicines management, stock control and unsafe storage. There was also a worrying lack of managerial and clinical supervision of primary care staff. Staff shortages, including vacant posts and sickness absence, had affected the delivery of mental health services. The waiting time for a routine assessment was too long but the team responded promptly to urgent referrals. There was an effective weekly team meeting and good interaction with prison staff.

Independent Monitoring Board

28. 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 April 2018, the IMB reported that the inadequacy of the mental health provision at Stocken remained a concern. Staff shortages affected the provision. The IMB reported that multi-disciplinary involvement at ACCT reviews appeared to be working well, with case managers holding regular informal meetings to share good practice and the duty governor checking ACCT entries each weekend.

Previous deaths at HMP Stocken

29. Mr Maxfield was the sixth prisoner to die at Stocken, and the first self-inflicted death, since January 2017. Three of the previous deaths were from natural causes, one was drug-related and the cause of the other death has not been determined.

30. In our investigation into the death of a prisoner on 30 October 2017 we found that staff delayed going into the prisoner's cell and did not radio a medical emergency code. This caused delay in calling an ambulance during the emergency response. The investigation also found deficiencies in the prison's mental health assessments in that a registered mental health nurse should have assessed or reviewed the prisoner's mental health, but did not do so.
31. In our investigation into the death of a prisoner in March 2018, we found again that the first officer who responded to the emergency did not radio a medical emergency code as he should have done. He also did not enter the cell immediately. This contributed to a significant delay in calling the ambulance.
32. Stocken told us in response that all staff would be reminded through a Governor's notice and full staff briefing by October 2018 of the circumstances in which they should radio a medical emergency code and go into a cell during patrol or night state. Stocken also told us that they would issue all staff with reference cards by December 2018 with the correct code to call during a medical emergency.

Assessment, Care in Custody and Teamwork

33. 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011. 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.
34. 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.

Incentives and Earned Privileges (IEP) Scheme

35. Each prison has an Incentives and Earned Privileges scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are three levels, basic, standard and enhanced.

Personal Officer and Key Officer schemes

36. It has never been mandatory for prisons to operate a personal officer scheme. Where they did exist, prisoners were assigned a named officer as their personal officer to be their first port of call to help with anything from sentence planning to

food requirements to bereavements. This provided an opportunity for staff to engage with prisoners in a meaningful way. However, if a personal officer was responsible for too many prisoners, the role could become nothing more than a box-ticking exercise.

37. The personal officer scheme has now been replaced by the key worker scheme, which is designed to help reduce violence and self-harm by encouraging meaningful contact and positive relationships between officers and prisoners. All prisoners will have a key worker whose role is to guide, support and coach them through their custodial sentence and with whom they can establish a relationship of support and trust. The intention is that key workers will support prisoners to learn alternatives to the unhealthy strategies many adopt to cope with stress, including drug use and harming themselves or others. Each key worker will have around six prisoners and will have dedicated time - on average 45 minutes a week per prisoner – and will meet each prisoner weekly or fortnightly.
38. The Prison Service began rolling the key worker scheme out across the prison estate in September 2017, and implementation began at Stocken in October 2018. In its latest inspection in February 2019, HMIP inspectors noted that Stocken planned to allocate a key officer to all prisoners by April 2019. At the time of the inspection just over a third of prisoners had one.

Key Events

2017

39. On 28 January 2017, police arrested Mr Alan Maxfield for false imprisonment and making threats to kill his wife. Mr Maxfield said in court that he had planned to kill himself in front of his wife during the commission of his offence. The following day, he told a mental health worker that he had a diagnosis of depression and was taking venlafaxine (an antidepressant). He also said that he wanted to kill himself if released and had a plan to hang himself at home. The mental health worker assessed Mr Maxfield as being at high risk of suicide and self-harm.
40. On 31 January, Mr Maxfield was remanded to HMP Nottingham. This was his first time in prison. At reception, Mr Maxfield was tearful and said that he was going to hang himself after his next court hearing. Officers started suicide and self-harm prevention monitoring (known as ACCT). The ACCT remained open for 22 days. It was closed when Mr Maxfield said that he no longer wanted to kill himself.
41. In May, Mr Maxfield was sentenced to seven years imprisonment. During an independent assessment requested by his defence team, he told a psychiatrist that he had tried to kill himself by taking an overdose of analgesia and alcohol when he was 13 years old. He said that he had also taken an overdose of drugs, antibiotics and alcohol in 1996 and had been under the care of mental health professionals on two occasions.

HMP Stocken

42. On 11 May 2017, Mr Maxfield transferred to HMP Stocken. At his reception health screening he told the nurse that he did not feel suicidal or like self-harming. He said that he had been sectioned under the Mental Health Act in 2001, and that he had been admitted to a mental health crisis unit for seven days in 2016. He had also tried to kill himself with an overdose on the day of his offence.
43. The nurse recorded that Mr Maxfield had been diagnosed with severe depression but had good eye contact, was cheerful and communicated well. She assessed that his mental health was stable but referred him to the mental health team. She also assessed that Mr Maxfield could hold his medication in possession.
44. On 23 May, officers moved Mr Maxfield to a single cell on a residential wing. (He was assessed as a 'standard risk' in his cell-sharing risk assessment so he was able to share a cell.) He remained in the same cell until he died.
45. On 12 June, a mental health support worker reviewed Mr Maxfield. He repeated that he had tried to kill himself with an overdose when he was 13 years old and again in January 2017, and that he had suffered from severe depression and had been sectioned under the Mental Health Act in 2001.

46. Mr Maxfield told the mental health support worker that after he committed his offence in 2017, his mental health deteriorated. Mr Maxfield said that a psychiatrist at HMP Nottingham had prescribed him with 37.5mg of venlafaxine (an antidepressant), which was “working perfectly”. He said that he often had thoughts of self-harm but managed them well and would not act upon them.
47. The mental health support worker recorded that Mr Maxfield was polite and maintained good eye contact. She assessed that he did not present with any obvious signs of depression, anxiety or paranoia. She assessed that he did not need to be under the care of the mental health team. Mr Maxfield agreed and said he did not think he needed mental healthcare input at that point. The mental health support worker explained to him how to contact the team if he needed support.
48. Later that month, Mr Maxfield started working as a healthcare mentor running smoking clinics in the healthcare department.
49. In August, Mr Maxfield’s IEP level was upgraded to ‘enhanced’ and he remained an enhanced prisoner until he died. During the following weeks, officers recorded several positive comments about his behaviour in his NOMIS records (the electronic records system).
50. In September, Mr Maxfield told a prison GP during a medication review that he felt well taking venlafaxine and wanted to continue with the same dose. The GP recorded that Mr Maxfield was polite, looked well and had good eye contact. She assessed that his mental health was stable. In November, the GP carried out a further review of Mr Maxfield’s medication, noting no concerns.
51. On 28 September, Mr Maxfield started working in the bicycle maintenance workshop.
52. On 5 December, Officer A recorded that he was Mr Maxfield’s personal officer. Officer A noted that Mr Maxfield had received good reports for his work and that he interacted well with peers, showing good interpersonal skills. He made no further entries in Mr Maxfield’s electronic record.

2018

53. On 14 February 2018, Mr Maxfield self-referred to the mental health team. He asked a doctor to end his medication prescription as he had been feeling well for six months. The doctor recorded that Mr Maxfield practised yoga, ran twice a week and presented well. She planned for Mr Maxfield to take the remainder of his medication on alternate days for two weeks before stopping. (Mr Maxfield later admitted that he had stopped taking venlafaxine immediately.)
54. During the following months, officers continued recording positive comments about Mr Maxfield and raised no concerns about him. The workshop instructor told the investigator that Mr Maxfield was an excellent example to his peers and a model prisoner. Mr Maxfield was also a reading mentor and taught other prisoners to read.
55. On 14 August, Mr Maxfield self-referred to the mental health team and asked a mental health support worker to re-prescribe him venlafaxine. He told her that

during the previous two months he had lacked motivation and wanted to self-isolate. He said that he had stopped attending the gym and had started to feel frustrated and paranoid. He told her that he had suicidal thoughts and planned to kill himself by attaching his bedsheet to the back of his cell door and hanging himself.

56. The mental health support worker immediately started ACCT monitoring for Mr Maxfield and completed the concern and keep safe form. She told the investigator that Mr Maxfield was clearly at high-risk of suicide and self-harm. She added Mr Maxfield to the mental health team's case load and arranged an urgent appointment with the GP to review his medication.
57. At around 3.00pm, Officer B held an ACCT assessment interview, Mr Maxfield told her that he had paranoid thoughts but felt that he could control them. He said he thought the comments he had made to the mental health support worker had been taken "out of proportion" and that he did not need to be monitored under ACCT. Mr Maxfield believed that he would be better after taking his medication.
58. At around 4.00pm, Supervising Officer (SO) A chaired Mr Maxfield's first ACCT case review. The mental health support worker and a nurse also attended. Officer B did not attend in person but she spoke to SO A before the review started. SO A recorded that Mr Maxfield said that his thoughts of self-harm and suicide were a "normal" occurrence and repeated that he believed that he should not have stopped taking his medication.
59. SO A assessed that Mr Maxfield's level of risk was low. He set his observations at once per hour during the day and every three hours during the night. SO A also completed a caremap. The caremap identified one issue - to review Mr Maxfield's medication - and one action - for the mental health support worker to arrange a doctor's appointment for a medication review. (She had already arranged the appointment.) No other issues and actions were identified and the caremap was not subsequently updated.
60. On 15 August, a doctor reviewed Mr Maxfield. Mr Maxfield repeated that he wanted to re-start his medication so she prescribed him 37.5mg of venlafaxine. (This was the same dose he had received before, which had worked well.) The doctor noted that Mr Maxfield was polite and had good eye contact. Thereafter Mr Maxfield collected his weekly dose of venlafaxine from the healthcare department every Thursday. Records show that he did not miss any doses.
61. On 20 August, SO A chaired another ACCT review. The mental health support worker also attended. Mr Maxfield said that he was starting to feel that his mood, sleep and motivation were better since his medication had been re-instated. SO A assessed that Mr Maxfield's risk continued to be low and reduced the observations to three per day and three during the night. Staff recorded that the ACCT was to remain open while the medication took its full effect on Mr Maxfield.
62. On 29 August, SO A and a mental health social worker carried out the final ACCT case review on Mr Maxfield. Mr Maxfield said that he was feeling well, had started to go back to the gym, and was enjoying his work. He said he was

confident that he was going to remain mentally stable and said that he did not have any thoughts of suicide or self-harm. SO A closed the ACCT.

63. On 5 September, a doctor reviewed Mr Maxfield's medication. Mr Maxfield told her that he felt better after starting to take venlafaxine again and that he did not want to change his dosage of 37.5mg.
64. On 13 September, SO A carried out an ACCT post-closure interview for Mr Maxfield. Mr Maxfield said that he was well and that his concerns had been addressed. ACCT monitoring was not re-started. SO A told the investigator that at this point he assessed that Mr Maxfield did not present with any risk factors for suicide and self-harm.
65. On 11 November, 15 December and 26 December, Mr Maxfield made three phone calls to the same number and spoke to two friends. The investigator listened to the phone calls. During the conversation on 15 December, Mr Maxfield thanked his friend for a letter he had received two days earlier. In the letter, she had informed Mr Maxfield about the death of an ex-girlfriend. They discussed the circumstances of her death. Mr Maxfield reflected that the events were very sad but he appeared to be positive during all the calls.
66. During the period following the closure of the ACCT, officers made around 15 notes in Mr Maxfield's NOMIS records describing his excellent work at the workshop and his good behaviour. Mr Maxfield was subject to two random mandatory drugs tests while at Stocken which returned negative results.

2019

67. On 3 January 2019, Mr Maxfield resigned from his job in the bicycle maintenance workshop. He was to start working as a picker and packer for the DHL warehouse on 7 January. Mr Maxfield told the bicycle workshop instructor that he wanted to save money for a possible move to a category D prison and the DHL work would pay him more money. The same day, Mr Maxfield collected his seven tablets of venlafaxine from the healthcare department.
68. On 5 January, at around 4.55pm, a prisoner spoke to Mr Maxfield. (The prisoner had been trained by the Samaritans as a 'listener' to support other prisoners.) He was working at the DHL warehouse and asked Mr Maxfield if he was looking forward to starting his new job. Mr Maxfield said that "he could not wait so that he could save some money" and mentioned that his birthday was on Tuesday (8 January). The prisoner said that Mr Maxfield appeared to be fine and he had no concerns about him.
69. At around 8.00pm, Operational Support Grade (OSG) A carried out the evening roll count on F wing. He said that when he arrived at Mr Maxfield's cell, he looked through the observation panel and saw Mr Maxfield "up and about, walking in his cell". He told the investigator that he did not notice anything of concern about Mr Maxfield.

Events on 6 January 2019

70. At around 5.13am, OSG A started the morning roll count on F wing. When he arrived at Mr Maxfield's cell, he saw that Mr Maxfield had partly covered the observation panel with paper. OSG A noted that "the bed had not been slept in". He tried to wake Mr Maxfield by calling his name but did not get a response.
71. OSG A went off to check on three prisoners who were on ACCT monitoring before returning to Mr Maxfield's cell. He turned the lights in the cell on. He said that he "vaguely [saw] something behind the door" that looked like "part of a body". He told the investigator that he was confused but thought that Mr Maxfield may have been sleeping behind the door.
72. OSG A went to the wing office to phone the Custodial Manager (CM). He told him that Mr Maxfield was not responding. The CM used his radio to ask Officer C and Officer D to go to F wing.
73. At around 5.28am, Officer C, Officer D and Officer E arrived at Mr Maxfield's cell. Officer C saw that Mr Maxfield was hanging and called a code blue emergency over the radio. (A code blue emergency indicates that a prisoner is unconscious or having difficulty breathing.) Officer C told the investigator that he had to call the emergency code three times before he received an acknowledgement from OSG B who was in the control room. OSG B called an ambulance at around 5.31am.
74. Officer D accessed the cell through a small gap as Mr Maxfield's body was blocking the door. Mr Maxfield had used a ligature made of a torn piece of bed sheet passed around a hinge at the top left-hand side corner of the door. Officer D cut the ligature, and officers placed Mr Maxfield on the floor. Officer E examined Mr Maxfield and found no pulse. He also noted that Mr Maxfield was cold and pale, and his pupils did not react to the light of his torch. Officer C said that Mr Maxfield's body was stiff but Officer E started cardiopulmonary resuscitation (CPR).
75. At around 5.35am, the CM arrived at the cell with the defibrillator and officers attached the patches to Mr Maxfield's body. The defibrillator advised to continue with CPR. However, at 5.50am the CM asked staff to stop performing CPR as Mr Maxfield was showing obvious signs of rigor mortis. The clinical reviewer said that the officer's decision to stop CPR was appropriate.
76. At around 6.04am, the control room log and ambulance records show that the ambulance arrived at the prison gate. The ambulance records also show that at paramedics reached Mr Maxfield's cell at about 6.16am. At 6.17am, the paramedics pronounced Mr Maxfield dead.

Letters and medication found in Mr Maxfield's cell

77. After Mr Maxfield's death, the police found diary-like letters which he had written. The letters were not dated. They also found a drawing of a prisoner hanging from a noose. In the letters Mr Maxfield said that depression and suicidal thoughts had always been present in his life. He wrote that he took his first overdose in 1987 and had often considered killing himself since 1989.

78. The police also found one box of venlafaxine (dated 14 December 2018) with five tablets in it. There was no sign of the boxes of venlafaxine Mr Maxfield had been issued on 21 and 28 December 2018 and 3 January 2019. Many tablets of cholecalciferol (a Vitamin D supplement) and cetirizine (an antihistamine) were also found. All of this medication had been prescribed to Mr Maxfield.

Post-mortem report

79. The post-mortem examination found that Mr Maxfield's cause of death was hanging. The toxicology analysis did not find the presence of any illicit drug in Mr Maxfield's body. Venlafaxine was found at sub-therapeutic levels.

Contact with Mr Maxfield's family

80. At 9.30am on 6 January, an officer and an SO went to the address recorded for Maxfield's brother, his nominated next of kin. On arrival they found that Mr Maxfield's brother was not living in the property.
81. The next day, the officer contacted the police and asked them to locate Mr Maxfield's brother. The police could not find him but located Mr Maxfield's father. The officers went to Mr Maxfield's father's address and broke the news of his son's death. Mr Maxfield's father had no information about his other son.
82. On 18 January, the SO visited Mr Maxfield's father to offer further information and support. Mr Maxfield's father told the SO that Mr Maxfield's brother had confirmed, both to his sister and to the coroner, that he did not want to take on the role of next of kin. Mr Maxfield's father agreed to take on the role and the prison continued communicating with him thereafter.
83. Mr Maxfield's funeral took place on 20 February 2019. The prison contributed to the funeral costs in line with national policy.

Support for prisoners and staff

84. In line with PSI 02/2018, *Post-incident care*, the head of safer custody spoke individually to the staff involved in the emergency response and offered them support. The staff care team also offered support to staff. No hot debrief was carried out, which would have been a good practice.
85. The prison posted notices informing other prisoners of Mr Maxfield's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Maxfield's death.

Information received after Mr Maxfield's death

86. After Mr Maxfield's death, prisoners told staff that two prisoners had been bullying Mr Maxfield in the bicycle workshop. A prisoner told the investigator that the prisoners were calling Mr Maxfield 'John Worboys' (meaning a rapist or sex offender) and a 'nonce' and were making comments about his offence.
87. Another prisoner told the investigator that Mr Maxfield never showed any signs that he was affected by this, and that the prisoners' actions were not intimidating, "just banter". The prisoner speculated that bullying could have

made Mr Maxfield feel down but said that Mr Maxfield never mentioned the issue to him. The workshop instructor said that, given Mr Maxfield's personality and that of the other prisoners involved, he thought it was unlikely that Mr Maxfield had been affected by their behaviour.

88. After Mr Maxfield's death, the prison challenged the prisoners involved and assessed that they were unlikely to bully anyone else as they expressed sorrow and regret. The prison informed the police and remained open to making further investigations and taking further action.

Findings

Assessment and Management of risk

89. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, requires all staff in contact with prisoners to be aware of the triggers and risk factors that might increase a prisoner's risk of suicide and self-harm, and to take appropriate action, including making referrals to the mental health team or starting ACCT procedures.
90. Mr Maxfield's risk factors for suicide and self-harm included a history of severe depression, a significant history of self-harm and suicide attempts, the violent nature of the offence against his wife, the breakdown in their relationship, and the fact that this was his first time in prison.
91. We consider that staff assessed and managed Mr Maxfield's risk appropriately until August 2018. He was appropriately referred to the mental health team and his GP monitored his health and medication well. Mr Maxfield's mental appears to have remained stable until he chose to stop taking his antidepressants in February 2018.
92. On 14 August 2018, the mental health support worker appropriately started ACCT monitoring when Mr Maxfield told her that he was feeling depressed and paranoid and had a plan to kill himself. She appropriately arranged an urgent appointment with a doctor to review Mr Maxfield's medication and spoke to wing staff about her concerns.
93. However, we consider that staff did not make full use of the ACCT process thereafter and missed the opportunity to explore the reasons for Mr Maxfield's suicidal feelings and put support in place.

Multidisciplinary working

94. ACCT guidance says it is essential that case reviews should be multidisciplinary, and that care planning takes place with input from all departments with knowledge of the person at risk.
95. The mental health support worker told the investigator that, during the first ACCT case review, the officers did not listen to her opinion that Mr Maxfield was at high risk of suicide and self-harm. She thought this was in part because Mr Maxfield himself was saying that "[she] was making a big deal" and that he did not need to be managed under ACCT. She told the investigator that, as a result, the officers were thought that she had over-reacted and dismissed her views. She said that she was surprised that SO A assessed Mr Maxfield as low risk during the first ACCT case review, only a few hours after she had opened the ACCT. She told the investigator that she did not take part in any decisions on assessment of risk, ACCT care-planning or the level of observations, because these decisions "were the responsibility of the officers only".
96. SO A challenged the mental health support worker's comments. He told the investigator that she was heard and was fully involved in all decisions.

97. We are surprised that Mr Maxfield's risk was set as 'low' at the first ACCT review. Mr Maxfield had self-referred to the mental health team and told the mental health support worker that he had suicidal thoughts and a detailed suicide plan, that he lacked motivation and wanted to self-isolate, that he had stopped attending the gym, and that he had started to feel frustrated and paranoid. We recognise that the final decisions are made by prison staff, but the views of healthcare staff and other specialists should be taken fully into account in ACCT reviews. We are concerned that the mental health support worker's views were not given more weight in the assessment of Mr Maxfield's risk as she had a greater knowledge of Mr Maxfield's history and risk factors, while SO A had never met Mr Maxfield before.

ACCT caremap

98. PSI 64/2011 requires caremaps to reflect the prisoner's needs, level of risk and their triggers of distress. They must be tailored to meet prisoners' individual needs and reduce risk. They must be time-bound and should be updated following every case review.
99. At the ACCT assessment and first ACCT review Mr Maxfield attributed all his issues to the fact that he had stopped taking his medication, and this was the only action identified in the ACCT caremap.
100. We are concerned that staff were not in a position at the first ACCT review to know if Mr Maxfield's suicidal thoughts were the result of stopping his medication, as he said. Even if they were, it would take a few weeks before restarting his medication would start to have an effect and we would, therefore have expected to see other actions in the care map. We are concerned that staff focussed on what appeared to be an easy problem to fix, and did not consider Mr Maxfield's underlying risk factors, which were unchanged.
101. This meant that the opportunity was missed to explore Mr Maxfield's risk factors and to put support in place to mitigate those risk factors. Although SO A told the investigator that Mr Maxfield's suicide plan would have been discussed at ACCT case reviews, we found no record that it was discussed or of anything that could have been put in place to safeguard him (for example, sharing a cell). We note that Mr Maxfield killed himself on 6 January 2019, just as he had described to the mental health support worker on 14 August.
102. Our findings in this investigation are consistent with those made by HMIP when they inspected Stocken shortly after Mr Maxfield's death.

Meaningful contact

103. In April 2014, we published a Learning Lessons Bulletin on 'Risk Factors in Self-Inflicted Deaths in Prison'. We identified that staff often place too much weight on how a prisoner presents and what he says about self-harm, rather than considering existing risk factors. We highlighted that prisoners will often withhold the extent of their distress from staff, and evidence of risk should, therefore, be fully balanced against how the prisoner presents.

104. Mr Maxfield appears to have been a private individual who did not associate with many prisoners, although he got on well with staff. The police investigation found that he spent most of his free time standing on the wing on his own.
105. It appears that Mr Maxfield did not disclose his feelings to staff and that they were misled by his apparently cheerful presentation. In the weeks before he spoke to the mental health support worker about his suicidal thoughts on 14 August, all the entries in his electronic prison record are about his excellent behaviour at work, describing him as mature, intelligent, a good communicator, confident, helpful and polite, with no hint at all that he might pose a risk to himself. The same is true of the months before he killed himself in January 2019. Officer A, who was Mr Maxfield's personal officer, made only one entry in his electronic records – in December 2017 - more than a year before Mr Maxfield died. Officer A told the investigator that he did have interactions with Mr Maxfield but did not record them because they did not raise any concerns.
106. At ACCT reviews Mr Maxfield assured staff that he would speak to them if he had any problems in future, but he did not do so, even though it is clear from the notes he left in his cell that he was having suicidal thoughts on a regular basis before he died.
107. At the time of Mr Maxfield's death, Stocken was working towards implementing the new key officer scheme, and Mr Maxfield would have been allocated a dedicated key officer in due course. We cannot say whether Mr Maxfield would have felt able to share his concerns with his key worker, but it would have provided an opportunity for him to do so.
108. We recognise that Mr Maxfield's very positive presentation and behaviour at Stocken made it difficult for staff to identify his risk. We make the following recommendations:

The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular that they:

- **identify and consider all risk factors when assessing a prisoner's level of risk of self-harm and suicide;**
- **adequately complete ACCT caremaps taking appropriate long-term actions to address known risk factors; and**
- **work collaboratively with staff of all disciplines when assessing a prisoner's risk and making decisions on care planning.**

The Governor should ensure all prisoners have meaningful contact with identifiable wing officers who regularly check their wellbeing and record their contact in line with the prison's key officer scheme.

Bullying

109. There is no evidence that Mr Maxfield told staff that he was being bullied in the bicycle workshop. The staff we interviewed said they knew nothing about it. We cannot say whether, if at all, this contributed to his decision to kill himself.

Mental healthcare

110. The clinical reviewer found that some areas of the mental healthcare provided to Mr Maxfield at Stocken were not equivalent to what he would have received in the community. The clinical reviewer is, however, satisfied that this did not contribute to Mr Maxfield's death.

Assessment

111. Mental health assessments should be carried out by a qualified practitioner. Depending on the nature of the prisoner's issues, the assessment might be carried out by a GP, someone from the primary care team or a member of a specialist mental health in reach team. Mr Maxfield's mental health assessments at Stocken were carried out by a support worker, not by a qualified mental health nurse.
112. The clinical reviewer commended the mental health support worker for keeping excellent records in SystemOne (the electronic clinical record) and for providing a comprehensive assessment of Mr Maxfield's mental health. He found that given her diligence and the appropriate input from GPs, there was no negative impact on Mr Maxfield.

Care plans

113. Healthcare staff did not produce a comprehensive care plan for Mr Maxfield's mental health issues during his time at Stocken. The clinical reviewer noted that on 27 September 2018, the mental health support worker produced a care plan based on her previous meetings with Mr Maxfield but she did not involve Mr Maxfield in drawing up the plan. Mr Maxfield should have been involved in this.

Continuity of care

114. Mr Maxfield was discharged from the mental health team's caseload in error for about a month after October 2018. The mental health support worker said that this could have been due to a mistake by a member of healthcare staff using SystemOne, ticking the wrong box and removing Mr Maxfield from her waiting list. We note that the discharge was for a very short period, however, and that as soon as she realised that Mr Maxfield was no longer on her waiting list, she sought to re-engage with him.
115. The Head of Healthcare told the investigator that the mental health team at Stocken have now reviewed their systems to ensure that all mental health assessments are completed by a qualified practitioner. She also said that all prisoners on the mental health team caseload will have a comprehensive care plan and risk assessment with the prisoner's involvement. The Head of Healthcare and the mental health support worker also said that the mental health team now uses a case management function in SystemOne to ensure that no patient is inadvertently discharged from their care. We are pleased to see that Care UK's own investigation identified the issue and made a recommendation to introduce an effective caseload management system at Stocken.

Medication

116. It is curious that, after Mr Maxfield placed so much emphasis on the need to take antidepressant medication to improve his mood, there are indications that he may not have been taking the full dose at the time of his death. The levels found in his blood after his death were below the levels he had been prescribed, and three boxes of recently issued medication could not be accounted for. This raises the possibility that he was trading his medication for some reason, although we cannot be certain about this.
117. We make the following recommendation:

The Head of Healthcare should provide the Ombudsman with evidence of what has been done to ensure that:

- **a qualified practitioner carries out mental health assessments;**
- **there are no unjustified interruptions in service provision; and**
- **all prisoners on the mental health team's caseload have a patient-centred care plan and risk assessment.**

Emergency Response

118. Prison Service Instruction (PSI) 03/2013 on medical emergency response codes requires that a code blue is called if a prisoner has breathing difficulties or is unconscious so that an ambulance is called immediately. The PSI says that it is better for staff to err on the side of caution and call an emergency code when the situation is not clear.
119. PSI 24/2011 on management and security at nights requires that all prisoners are locked in their cells during night state. Under normal circumstances, the night orderly officer must give authority to unlock a cell during night state, and no cell should be opened unless at least two or three members of staff are present, one of whom should be the night orderly officer. However, the PSI states that the preservation of life must take precedence. It says that where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the night orderly officer and an individual member of staff may go into the cell on their own. However, night staff should not take action that they feel would put themselves or others in unnecessary danger.
120. The PSI states that before going into a cell, staff should make every effort to gain a verbal response from the prisoner. This, together with what the member of staff observes through the panel and any knowledge of the prisoner, should inform a rapid dynamic risk assessment of the situation and a decision about whether to enter immediately or wait for assistance.
121. In line with the PSI, Stocken's security strategy states that the preservation of life overrides security concerns in the case of a life-threatening emergency. It says that a member of staff may enter a cell with caution, ensuring their own safety under these circumstances.

122. We do not say that OSG A should necessarily have entered the cell on his own when he found Mr Maxfield unresponsive in his cell. However, we are concerned that he did not act with sufficient urgency, that he did not use his radio to call an emergency code or ask for assistance, and that he ignored clear signs that Mr Maxfield's welfare could have been at risk. These included:
- the observation panel being partially obstructed;
 - Mr Maxfield's bed having not been slept in;
 - he saw "part of a body"; and
 - he could not obtain any response from Mr Maxfield.
123. It was 15 minutes before a code blue emergency was called and an ambulance was requested. This was an unacceptable delay and meant that an ambulance was not called immediately and staff were not sufficiently aware of the serious nature of the incident to enable them to respond appropriately.
124. There was also an unacceptable delay of 12 minutes in paramedics reaching Mr Maxfield's cell from the prison's gate.
125. Although the clinical reviewer said that the delays in this case did not impact the outcome for Mr Maxfield (as he appears to have been dead for some time), they could be crucial in other cases.
126. We are very concerned that this is the third investigation since January 2017 in which we found delays during the emergency response. Stocken does not have 24-hour healthcare provision. This makes it all the more important that staff use the emergency medical code system effectively.
127. In response to a previous PPO recommendation on this point the prison told us that they would remind all staff of the circumstances in which they should radio a medical emergency code and go into a cell during patrol or night state by October 2018, and would issue all staff with reference cards with the correct code to call during a medical emergency by December 2018. It is, therefore, very disappointing to find the same failings occurring again in January 2019. The prison clearly needs to take further measures to ensure staff know how to respond in medical emergencies, since the measures they have taken so far have not been effective.
128. We make the following recommendations:

The Governor should:

- **ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies so that there is no delay in calling a medical emergency code or calling an ambulance; and**
- **review arrangements for paramedics' access to a prisoner to reduce avoidable delays.**

The Prison Group Director for the North Midlands should provide the Ombudsman with an account of the action he is taking to improve the response to medical emergencies at Stocken.

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