Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lewis Jeffers, a prisoner at HMP Stocken, on 25 November 2020

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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

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 Lewis Jeffers died on 25 November 2020, after he strangled himself with a ligature at HMP Stocken. He was 26 years old. I offer my condolences to Mr Jeffers' family and friends.

Mr Jeffers had been at Stocken for just over eight months when he died. During that time, he was monitored under suicide and self-harm procedures (known as ACCT) on five occasions as he was a prolific self-harmer. On 1 October, staff started the last period of ACCT monitoring, which was ongoing when Mr Jeffers died.

On the day he died, staff should have checked on Mr Jeffers four times an hour. We are very concerned that on 13 occasions that day, staff recorded that they had carried out the check when they had not. We understand that disciplinary action was taken against the staff involved and the Governor has reminded staff of their responsibilities.

We have a number of other concerns about the ACCT management. While case reviews were detailed and healthcare staff usually attended, the quality of care plans was poor, and actions were sometimes signed off too quickly. Some ACCT records were illegible.

I am also concerned that there was a delay of over ten minutes in staff entering Mr Jeffers' cell when they saw his observation panel was covered. The Governor needs to ensure that staff know what to do in these circumstances and that they act urgently, especially if the prisoner is being monitored under ACCT.

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 **April 2022**

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Summary

Events

1. On 30 August 2017, Mr Lewis Jeffers was sentenced to four years in prison for harassment without violence and attempting to take a child. He was released on 2 October 2019 but recalled on 19 November. Mr Jeffers was moved to HMP Stocken on 13 March 2020.

2. Mr Jeffers frequently self-harmed, usually by cutting. Staff monitored him under suicide and self-harm procedures (known as ACCT) on five occasions at Stocken. He generally engaged with staff, including the substance misuse team and counselling services, but had periods where he resorted to cutting and overdoses. At other times, he was cheerful and future focussed.

3. On 1 October, staff started the last period of ACCT monitoring, which was ongoing when he died.

4. On 25 November, Mr Jeffers was subject to four ACCT checks an hour. At 7.55pm, when an officer went to Mr Jeffers' cell to carry out an ACCT check, he was unable to see into the cell because Mr Jeffers had covered his observation panel with paper. The officer got no response when he asked Mr Jeffers to remove the obstruction, so he went outside to look through the cell window, but the curtains were closed. The officer went back to the cell door and, when he could still not get a response, he went to the wing office and called the Night Orderly Officer for assistance. Staff arrived and went into the cell 11 minutes after the officer had first tried to carry out the ACCT check.

5. Staff found Mr Jeffers with a ligature around his neck. They cut the ligature, called a medical emergency code and carried out cardiopulmonary resuscitation (CPR) until paramedics arrived at 8.49pm. After attempts to resuscitate him failed, the paramedics declared Mr Jeffers dead at 9.19pm.

Findings

6. On 25 November, there were 13 occasions where staff recorded that they had carried out an ACCT check when CCTV shows they did not. The Governor took disciplinary action against the staff involved. Around three weeks before, Mr Jeffers had complained verbally that some ACCT checks had been missed. We are concerned about the apparent lax attitude towards ACCT checks at the time. The Governor has since issued a Governor's Notice to remind staff of their responsibilities when checking prisoners on ACCT.

7. Most ACCT case reviews were multidisciplinary but there was one occasion where healthcare staff were not invited to a first case review as required. We found the quality of some care plans was poor and some actions were signed off too early. Some of the ACCT records were illegible, which is unacceptable.

8. Mr Jeffers asked to see a Listener (a prisoner trained by the Samaritans) on 23 October. There is a record that staff tried to find one, but no record that a Listener saw Mr Jeffers. Prisoners should have timely access to a Listener if requested.

9. There was a long delay in entering Mr Jeffers' cell. At the time, there was no local policy at Stocken for dealing with blocked observation panels. While the officer did try to find a way of seeing into the cell and then went to the wing office to call for help, this wasted valuable time. A Notice to Staff has since been issued which says that where a prisoner's life may be in danger, staff should summon assistance and remain at the cell.

10. The clinical reviewer found that the clinical care Mr Jeffers received was equivalent to that he could have expected to receive in the community. She considered there could have been better information sharing with the counselling service.

11. We found that some staff were not supported after Mr Jeffers' death.

12. The prison did not appoint a family liaison officer until the day after Mr Jeffers died. The family liaison officer was unsure whether Mr Jeffers' family had already been notified. He visited the family on 26 November, but they told him the police had informed them in the early hours of the morning.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with policy guidance and, in particular, they:
    - invite healthcare staff to the first case review and obtain a written contribution if they are unable to attend;
    - set caremap actions that are meaningful and individualised to address risk and sign them off as completed only once the issue identified has been fully addressed; and
    - make clear, readable and accurate records on the ACCT paperwork**.**
- The Governor should share this report with SO A, SO B and SO C so they are aware of the Ombudsman's findings and should arrange for them to have refresher ACCT training.
- The Governor should ensure that prisoners are given timely access to Listeners when requested.
- The Governor should ensure that all staff are aware of the local policy on responding to blocked observation panels.
- The Governor and Head of Healthcare should work with Safer Custody to establish joint information sharing from, and to, the counselling service to ensure that any relevant findings are available to key members of staff.
- The Governor and Head of Healthcare should ensure all staff who had significant involvement with any prisoner who dies in custody are offered support.
- The Governor should ensure that a family liaison officer is appointed as soon as possible after a death in custody and that decisions around how and when the family should be notified are properly recorded.

The Investigation Process

13. The original investigator issued notices to staff and prisoners at HMP Stocken informing them of the investigation and asking anyone with relevant information to contact him.

14. Another investigator took over the investigation and obtained copies of relevant extracts from Mr Jeffers' prison and medical records. The PPO investigation was suspended until the police completed their investigation.

15. The investigator interviewed 11 members of staff during 2021. NHS England commissioned a clinical reviewer to review Mr Jeffers' clinical care at the prison. The investigator and clinical reviewer jointly interviewed four healthcare staff. All the interviews were conducted by telephone due to the COVID-19 restrictions.

16. We informed HM Coroner for Rutland and North Leicestershire of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

17. The Ombudsman's family liaison officer contacted Mr Jeffers' mother, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She provided background information and asked several questions about Mr Jeffers' care at Stocken. Some have been addressed in this report while others have been addressed in separate correspondence.

18. Mr Jeffers's mother received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out two factual inaccuracies and amendments have been made to this report.

Background Information

HMP Stocken

20. HMP Stocken is a medium security prison in Rutland which holds up to 1,059men. Practice Plus Group (formerly known as Care UK) provides healthcare and mental health services. 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 (HMIP)

21. The most recent inspection of HMP Stocken was in February 2019. Inspectors reported that relationships between staff and prisoners were generally positive and the interactions they observed indicated that many, particularly residential, officers knew about the personal circumstances of the prisoners in their care. Inspectors reported that levels of self-harm had increased substantially since the previous inspection in 2015. They found that there was good support for prisoners, including a counselling service and an adequate number of Listeners (prisoners trained by the Samaritans to assist their peers).

22. Inspectors found serious weaknesses in healthcare provision, with some poor practice evident in the management of medicines, stock control and unsafe storage. They noted a worrying lack of managerial and clinical supervision of primary care staff. They found that staff shortages, including vacant posts and sickness absence, had affected the delivery of mental health services. They noted that the waiting time for a routine assessment was too long but that the team responded promptly to urgent referrals. Inspectors found that there was an effective weekly team meeting and good interaction with prison staff.

Independent Monitoring Board

23. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to April 2021, the IMB were confident that prisoners were treated fairly and humanely and that any reports of unprofessional staff attitudes were thoroughly investigated. They also considered mental health staffing levels to be adequate.

Previous deaths at HMP Stocken

24. Mr Jeffers was the third prisoner to die at Stocken since November 2018. One of the previous deaths was self-inflicted and the cause of the other was unascertained. We have previously made recommendations about ACCT management and delays in entering cells where the observation panel has been obscured.

Assessment, Care in Custody and Teamwork (ACCT)

25. 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.

26. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions 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, Management of prisons at risk of harm to self, to others and from others (Safer Custody).

Key Events

27. In August 2017, Mr Lewis Jeffers was sentenced to four years in prison for harassment and attempting to take a child. He was released on 2 October 2019 but was recalled on 19 November after his licence was revoked because he did not have a fixed address. He was moved to HMP Stocken on 13 March 2020.

28. Between 15 March and 20 September, staff supported Mr Jeffers using suicide and self-harm procedures (known as ACCT) on four occasions: from 15 to 26 March; from 23 April to 5 May; from 4 to 11 June; and from 4 to 20 September. Each time he self-harmed by cutting. His reasons ranged from wanting a move because he had experienced violence at Stocken in the past; he could not cope with being locked up for long periods with no visits (during the restricted regime due to COVID-19); he did not want to move wings; he was fed up with his cellmate; and the anniversary of his great-grandmother's death was approaching.

Final ACCT: 1 October 2020 onwards

29. On 1 October, staff opened an ACCT after Mr Jeffers made cuts to his wrist. He said he had done it because of a build-up of stress.

30. At the ACCT assessment interview the next day, Mr Jeffers said the anniversary of his great-grandmother's death was coming up, he was struggling to maintain contact with his family as they worked during the day (when he was out of his cell) and that officers were not helping him make extra calls. He said self-harming was a coping strategy and he did not intend to take his life.

31. Supervising Officer (SO) A chaired the first ACCT review later that day. Mr Jeffers said he was struggling with the very restricted COVID-19 regime. He had used psychoactive substances (PS) recently but was still engaging with his Inclusion worker. He said he would not use his in-possession medication to self-harm (the GP had prescribed it in-possession on 7 September).

32. On 9 October, a counsellor noted that she had received a referral to see Mr Jeffers.

33. On 10 October, Mr Jeffers cut his wrist and leg with a razor blade. The next day, a SO chaired a case review. Mr Jeffers was frustrated about the reduced regime and an upcoming adjudication, and said it was lonely on his landing. He said he would like to work. The SO noted he would make enquiries with Activities (but did not record this as a care plan action). Mr Jeffers made another cut to his wrist that evening.

34. At a case review on 12 October, Mr Jeffers said it was better being in a single cell. He implied that cell sharing contributed to his substance misuse issues. He said he had last 'used' just before his move to a single cell the previous week.

35. That evening, Mr Jeffers took a substantial amount of his prescribed medication including sertraline (an antidepressant), certirizine (an antihistamine), naproxen (a painkiller) and paracetamol. Staff took him to hospital, where he said that he had intended to take his own life. The hospital discharged him back to Stocken that night. A prison GP stopped him having medication in possession (meaning he

would have to collect it from the medication hatch and take it under the supervision of healthcare staff).

36. On 13 October, Mr Jeffers cut his arms after looking at a photograph of his great-grandmother and was treated in hospital. He had a counselling session a week later and talked about his great-grandmother and childhood.

37. On 21 October, Mr Jeffers tried to punch Officer A after he told Mr Jeffers to remove inappropriate posters from his wall and asked about damage to his sink. Mr Jeffers then caused more damage to his cell and cut himself. He was placed on a disciplinary charge. After Mr Jeffers made threats to end his life, staff moved him from F Wing to L Wing on constant supervision. Mr Jeffers told staff he would kill himself by any means possible.

38. On 22 October, a prison manager held a case review. Mr Jeffers seemed calmer but said Officer A had assaulted him the day before. Staff reduced observations to four an hour.

39. The same day, Mr Jeffers submitted a complaint alleging that Officer A had come into his cell the day before, grabbed his penis and told him he would smash his face in. Mr Jeffers said this had caused him to self-harm, that he did not trust officers anymore, felt on edge, and was having flashbacks. The incident was reported to the police, but they had not completed their investigation before Mr Jeffers died.

40. On 23 October, a prison manager adjourned the disciplinary hearing on the incident with Officer A to give Mr Jeffers time to contact his solicitor.

41. That evening, Mr Jeffers smashed up his cell and self-harmed by cutting. He said he could not cope with the upcoming anniversary of his great-grandmother's death and wanted to leave Stocken in a box. The cell was unusable. Earlier in the day, he had told an officer that he wanted to harm himself and asked to speak to a Listener. One was not available, but someone from N Wing told her they would try and make someone available. Because of the condition of his cell, staff moved Mr Jeffers to M Wing and put him back on constant supervision.

42. On 24 October, a prison manager and Custodial Manager (CM) chaired a case review. The CM noted Mr Jeffers' mood had changed for the worse, he did not make eye contact, and said he did not want to live any longer. He said he smashed up his cell because he did not want to be on that wing anymore and knew destroying it would prompt a move. He also said his medication was not helping him.

43. On 24 October, a prison manager noted that she had seen Mr Jeffers and he said was 'okay' and was enjoying talking about his life.

44. At a case review on 26 October, Mr Jeffers said his medication was not working and a nurse said she would ask a GP to consider reviewing it. (On 2 November, a GP increased Mr Jeffers' sertraline.) Mr Jeffers said he would not return to F Wing because of Officer A and he was waiting for the results of his complaint which had been referred to the police. He said he wanted a move from Stocken and that he would kill himself.

45. On 26 October, a counsellor (no name is recorded) saw Mr Jeffers and noted he was chatty – he talked about his father and growing up.

46. The same day, a prison manager held a disciplinary hearing following the cell damage. Mr Jeffers pleaded guilty. He was sentenced to seven days cellular confinement and 14 days loss of privileges, including the TV. He also had to pay back £83 damages over two years.

47. On 29 October, a prison manager chaired a case review. He noted that Mr Jeffers was in a more positive mood. He told him he would not return to F Wing while the assault complaint was investigated and would stay on M Wing for now. Mr Jeffers had missed a counselling session (possibly due to the move to M Wing) but the counselling service would be contacted. A nurse said that an appointment with the GP to discuss medication was still awaited and she would ask the GP if it could be increased without an appointment.

48. On the evening of 30 October, Mr Jeffers cut his arm and calf using a 'paper blade'. Staff held an ad hoc case review and placed Mr Jeffers on constant supervision. Mr Jeffers was taken to hospital but discharged back to Stocken that night.

49. On 2 November, a prison manager chaired a case review. Mr Jeffers had been occupying himself with some paper crafts and felt settled. The case review team maintained constant watch from 5.00pm to 8.00am, and during lunch, but reduced observations to four an hour during the rest of the day.

50. The same day, a prison manager saw Mr Jeffers, and he reminisced about his father. Mr Jeffers felt positive about things he could eventually do with his own daughter.

51. On 4 November, a prison manager told Mr Jeffers that she had referred the sexual assault allegation to the police and that Mr Jeffers should have heard from them about it.

52. The same day, a prison manager chaired a case review. Mr Jeffers said he was in a better place and was pleased to have moved to the north side of M Wing where he had a friend. He said he had been told that his counselling was due to start again but he knew that this could be delayed if there were more pandemic-related issues. Mr Jeffers said that his medication had been increased and had helped him feel more settled. Staff reduced observations to two an hour in the day and constant supervision at night.

53. On the morning of 6 November, a prison manager and a CM held a case review. (The case review is dated 29 October, but this is clearly incorrect.) Mr Jeffers said he was 'OK'. He had some of his personal property back and was making something for his daughter. They discussed the events leading up to his self-harm on 30 October and Mr Jeffers said he had been left for a period that evening without staff checks and could have been better supported. He also said that the recent counselling session may have fuelled some of his high feelings and the anniversary of his great-grandmother's death was also coming up. They discussed coping strategies. Staff stopped constant supervision and reduced observations to one an hour during the day with two conversations, and four observations an hour between 5.00pm and 8.00am.

54. On 9 November, a prison manager saw Mr Jeffers. He talked about making something for his daughter and reminisced about his great-grandmother.

55. On 10 November, a CM chaired a case review. Mr Jeffers was pleased with his cell move (to the north side of M Wing where he had a friend) and said that he and his friend would be able to go to the gym together. He also said that counselling was going well. The chaplaincy had arranged for him to light a candle in the chapel on the anniversary of his great-grandmother's death. Staff reduced observations to hourly during the day and twice an hour between 5.00pm and 8.00am (with two conversations a day).

56. On 18 November, a prison manager saw Mr Jeffers when he was on his way to the chapel to light a candle for his great-grandmother (it was the anniversary of her death) and for a short while afterwards. She noted that Mr Jeffers was talking positively about his great-grandmother and laughing.

57. The same day, a CM chaired a case review. Mr Jeffers spoke about his great-grandmother and they discussed the positives of her life including that she was 97 when she died. He said his counselling was helping him manage some of his longer-term issues. Mr Jeffers had not had any recent incidents or thoughts of self-harm and was keeping busy with his paper crafts.

58. On 22 November, Mr Jeffers cut his arms and legs. Mr Jeffers complained he had not received any vapes, but staff pointed out that he had not handed in a canteen sheet. Mr Jeffers said he had a stash of razors which he would use to self-harm again. Staff increased observations to two an hour with two conversations a day.

59. Later that morning, Mr Jeffers told staff he had taken 28 sertraline tablets. He said he had found them in a cell. While staff were seeking medical advice, Mr Jeffers cut his wrist. Mr Jeffers was taken to hospital but was discharged the same day. That evening, a CM held an ad hoc case review with just himself and Mr Jeffers. Mr Jeffers said he was feeling low because of his great-grandmother's anniversary. The CM increased observations to four an hour.

60. At a case review on 23 November, Mr Jeffers said he had self-harmed because his complaint of a sexual assault had not been taken seriously. Staff said it had been reported to the police. Staff decided that at Mr Jeffers' next session with a prison manager on 30 November he should raise the alleged assault with her (they noted they sent an email to her). Staff set observations at four an hour with conversations in the morning and evening. They scheduled the next review for 27 November.

61. Later that day, an officer noted that he had spoken to Mr Jeffers, who said everything had got on top of him again. He did not like being in isolation (under the COVID-19 rules, following his hospital visit) but understood the reasons for it although he was keen to get back to M Wing where he had a friend. (He had moved there by the time of his death, but the exact date is not clear.)

62. On 24 November, a prison manager planned to see Mr Jeffers again, but she was unable to as she was late getting to the wing. She noted that she sent a message to Mr Jeffers to say she would see him on 26 November instead.

25 November

63. Mr Jeffers should have been checked four times an hour on 25 November. However, CCTV shows that there were 13 occasions when officers did not carry out

observations even though they had recorded they had done so in the ACCT ongoing record:

- 7.32am and 7.50am entries by Officer B.
- 11.10am, 11.20am, 11.40am, 11.50am and 12.20pm entries by Officer C.
- 1.30pm and 2.40pm entries by Officer D.
- 5.10pm, 5.20pm, 5.30pm and 5.40pm entries by Officer E.

64. The CCTV also shows several important staff interactions with Mr Jeffers which were not recorded in the ACCT ongoing record. Significantly, at 4.38pm, Mr Jeffers smashed his observation panel because an officer told him he would have to wait for his medication until the main medications had been given out. She put Mr Jeffers on a disciplinary charge. She did not record the incident in the ACCT ongoing record, but put a record on NOMIS, almost two hours later, at 6.23pm.

65. CCTV shows that an officer checked Mr Jeffers twice – at 7.04pm and 7.17pm. She did not record the 7.04pm check and she recorded that she had carried out a check at 7.30pm.

Emergency response

66. At 7.55pm, during an ACCT check, an officer found that Mr Jeffers' observation panel was smashed and covered with a piece of paper on the inside. He asked Mr Jeffers to remove the obstruction but got no response. He went outside to look into the cell from the exercise yard. He could not see in because the curtains were closed, and Mr Jeffers did not respond when he knocked on the window and shouted his name. By 7.58pm, the officer had returned to the cell but was still unable to get a response. He went to the wing office and telephoned a CM (Oscar 1 – the Night Orderly Officer in charge of the prison overnight) for assistance to enter the cell. At 8.06pm, a SO and another officer attended the wing and after a further attempt to get a response from Mr Jeffers, the SO went into the cell followed by the others.

67. Mr Jeffers was on the floor near the window. There was blood around the cell and Mr Jeffers had a bandage around his neck which he had tightened with a pencil. Staff called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) and the control room called an ambulance.

68. The SO and an officer tried to find a pulse but could not. At 8.11pm, the CM arrived and directed they move Mr Jeffers out of the cell and start cardiopulmonary resuscitation (CPR). At 8.13pm, staff started CPR and continued until paramedics arrived at 8.49pm and took over. (The paramedics had been delayed by an accident on the A1.) Attempts at resuscitation were unsuccessful and at 9.19pm, the paramedics pronounced Mr Jeffers' death.

Contact with Mr Jeffers' family

69. On 26 November, the prison appointed an officer as the family liaison officer (FLO). He noted the FLO log to say that he was unclear whether Mr Jeffers' family had been given the news of his death. He visited the family that day, anyway, to break the news. They told him that the police had visited and informed them in the early hours of the morning.

70. Mr Jeffers' funeral was on 30 December. The prison contributed to the costs in line with national policy.

Support for prisoners and staff

71. After Mr Jeffers' death, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. However, one of the officers who discovered Mr Jeffers told the investigator he was speaking to the police at the time of the debrief. He considered he was not offered much support afterwards and found it quite traumatic to be involved in a safety exercise shortly after which was similar to the circumstances in which he had found Mr Jeffers.

72. We are also aware that an agency mental health nurse who dealt with Mr Jeffers frequently was not invited to discuss his death or offered any support.

73. The prison posted notices informing other prisoners of Mr Jeffers' 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 Jeffers' death.

Post-mortem report

74. The post-mortem report concluded that the cause of Mr Jeffers' death was ligature strangulation. The toxicology report said excessive levels of sertraline were detected, together with PS, but that neither were a significant contributory factor in Mr Jeffers' death.

Findings

Management of Mr Jeffers' risk of suicide and self-harm

75. 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.

76. Mr Jeffers was monitored under ACCT procedures on five occasions at Stocken, including periods on enhanced ACCT management due to his prolific self-harming. He was being monitored when he died on the evening of 25 November. We have a number of concerns about how ACCT observations were carried out and the management of the ACCT procedures.

ACCT checks 25 November

77. On the day he died, Mr Jeffers was on four observations an hour. We are very concerned that on 13 occasions that day, staff recorded that they had carried out ACCT checks when CCTV shows they did not.

78. The police carried out an investigation, but no criminal charges were brought against the staff involved. Afterwards, the prison carried out its own investigation into the actions of four officers and a SO (who was in charge of the wing that day). (One of the officers involved had resigned.)

79. Four officers were referred for disciplinary hearings. One was subsequently dismissed, one was demoted (and has since resigned from the Prison Service), One was removed from the field of promotion for two years and another officer was given formal advice and guidance.

80. The investigator found that at the time of Mr Jeffers' death it seemed to be common practice for officers to carry out ACCT checks between them on an ad hoc basis, regardless of whether a specific officer had been detailed to carry them out. The Governor told the investigator that this was not how he expected ACCT checks to be organised. After Mr Jeffers' death, the Governor issued a Governor's Order on staff responsibilities for ACCT supervision in December 2020, telling staff that if they were specifically detailed to manage an ACCT document on a wing, they were responsible for carrying out this duty to the end of their shift, and for handing over to another member of staff. The Order made clear that the responsibility for the ACCT included carrying out all observations and interactions and recording them in the ACCT log.

81. We found that some staff interactions with Mr Jeffers were not recorded in the ACCT document and that the times of some entries were inaccurate. The Governor's Order issued in December 2020 reminded staff that all staff who had contact with a prisoner subject to ACCT must make entries in the ACCT document, recording all significant events and conversations, and that observations should be recorded immediately or as soon as practicably possible. As the Governor has reminded staff of these issues, we do not make a recommendation.

ACCT checks 30 October

82. On the evening of 30 October, Mr Jeffers made cuts to his arm and leg, and when this was discussed with him on 6 November, he said staff had not been carrying out ACCT checks that evening.

83. That day, an officer had signed for four observation checks on Mr Jeffers at 6.15pm, 6.25pm, 6.40pm and 6.55pm. He recorded that at 7.05pm, he had answered Mr Jeffers' cell bell to find he had cut himself. He called a general alarm and staff, including a CM, attended. The CM told the investigator that he thought that the blood in Mr Jeffers' cell looked as if it had been there for some time, indicating that the ACCT checks had not been carried out as frequently as they should have been.

84. In light of the events of 25 November, when numerous ACCT checks were not carried out on Mr Jeffers and the records were falsified, we consider it very possible that Mr Jeffers' allegation that ACCT checks were not carried out on the evening of 30 October was true. However, the officer has since left the Prison Service, so we have not been able to interview him, and we can make no finding.

ACCT management

85. PSI 64/2011 says that healthcare staff should attend the first ACCT case review and that subsequent case reviews should be multidisciplinary where possible. While the majority of case reviews were attended by healthcare staff, there were no healthcare staff at the first case review held on 4 June. The case manager, SO B, did not record why and when he was interviewed seemed unaware that healthcare staff should always be invited to first case reviews.

86. The ACCT care plan should contain meaningful and individualised actions to reduce or mitigate risk of harm. An ACCT should be closed only once all actions have been completed. We are concerned that some actions on Mr Jeffers' care plans were signed off as completed when in fact nothing had been done to reduce Mr Jeffers' risk. For example, on 4 June, SO B identified that Mr Jeffers should have his medication reviewed by the mental health team and he set an action for himself to make a referral to the mental health team. He made the referral that day and signed the action off as completed. We consider that the important action here was that Mr Jeffers should have a medication review, not that he should be referred for a medication review. In fact, he was still waiting for a medication review at the next case review on 11 June, when SO B closed the ACCT.

87. Another example was on 2 October, when SO A added to Mr Jeffers' care map that he should maintain contact with his Inclusion worker (to address his substance misuse), and he set an action for himself to contact the Inclusion worker. SO A signed this action off the same day (even though Mr Jeffers had not had any contact with his Inclusion worker at that point). He also set an action for Mr Jeffers to carry on taking his medication "in an adult and responsible way", which he also signed off the same day. We do not consider that this was a meaningful action, and we cannot see how this was satisfactorily completed. Indeed, Mr Jeffers took an overdose 10 days later.

88. At interview, SO A and SO B said that subsequent case managers were expected to check care plans and see if any more actions were required to work towards identified goals. We consider this a risky and mistaken strategy as anyone looking

at the care plan would see that the actions had been closed and would, not unreasonably, consider that the issue had therefore been resolved. We consider that care plan actions should be left open until they have been completed and should then be signed off by whoever is conducting the ACCT review.

89. We also consider that there were actions that were not added to the care plan when they should have been. For example, when Mr Jeffers said at a case review on 11 October that he wanted to work, a SO noted that he would make enquiries with Activities, but he did not record it as an action.

90. There were also no care plan actions to address Mr Jeffers' statements that he was lonely. We note that from 9 October, Mr Jeffers was in a single cell. Staff should have considered moving him to a shared cell, which could have addressed his loneliness, as well as providing the protective factor of a cellmate. We note that staff thought that the move to a single cell was a good thing for Mr Jeffers because he thought sharing contributed to his substance misuse, but we consider that thought should have been given to finding him a suitable cellmate.

Quality of ACCT records

91. Some of the ACCT paperwork was very difficult to read. The investigator had to ask SO B to read out his care plan notes and the post-closure notes for the third ACCT because they were effectively illegible. There are further examples of records being difficult to read throughout the final ACCT, ranging from the names of case review attendees to who has signed off care map actions. This is unacceptable. It is essential that anyone who picks up the ACCT document can read the case review notes and the care plan, so they understand the prisoner's risks and the measures proposed to keep them safe.

92. There were also errors. On 16 March, the case review record completed by SO C noted that staff did not need to remove blades from Mr Jeffers (even though the previous day he had self-harmed by cutting). At interview, SO C said he had made a mistake on the form and that blades had already been removed from Mr Jeffers' cell. If so, this is an example of important information being recorded inaccurately. However, we note that Mr Jeffers cut himself again that evening and cut himself again with a razor the following day – which suggests that blades had not been removed. His care plan entries on the first ACCT are confusing and difficult to read, as are his observation instructions on 17 March which are crossed out. He told the investigator that he thought the subsequent case manager must have crossed out his observation instructions, but it remains unclear why the original details on the front sheet differ from those in the case review paperwork.

93. We make the following recommendations on ACCT management:

The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with policy guidance and, in particular, they:

- **invite healthcare staff to the first case review and obtain a written contribution if they are unable to attend;**
- **set caremap actions that are meaningful and individualised to address risk and sign them off as completed only once the issue identified has been fully addressed; and**

- **make clear, readable and accurate records on the ACCT paperwork.**

The Governor should share this report with SO A, SO B and SO C so they are aware of the Ombudsman's findings, and should arrange for them to have refresher ACCT training.

Access to Listeners

94. We are also concerned that when Mr Jeffers asked to see a Listener on 23 October, staff did not arrange for a Listener to be brought to him. There is a record that staff would try to find one, but no record that he saw one. We would expect a record to have been in the ACCT had he done so.

95. PSI 64/2011 says, 'Where a Listener scheme exists prisons must ensure that prisoners have timely access to Listeners wherever located'. We recommend:

The Governor must ensure that prisoners are given timely access to Listeners when requested.

Emergency response

96. It took 11 minutes for staff to enter Mr Jeffers' cell after first discovering he had covered his observation panel. When the officer asked Mr Jeffers to remove the obstruction and got no response, he went outside to see if he could look through the cell window but was unable to because the curtains were drawn. He got no response when he knocked on the window. He went back to the cell door and when he still could get no response, he went to the wing office and called the Night Orderly Officer for assistance.

97. An HMPPS Safety Briefing on Observation Panels, issued in February 2018, says that local safety measures should explain what staff should do if the occupant of a cell cannot be seen due to the panel being covered or blocked. It goes on to say that when staff discover that a panel has been blocked, and the prisoner does not comply with instructions to remove the blockage, they must take immediate action to remove the obstruction and check on the prisoner's welfare.

98. Mr Jeffers was known to be a prolific self-harmer and was on an ACCT with four observations an hour. We therefore consider that the officer should have regarded the blocked panel as an emergency and should have radioed for assistance straightaway when he got no response from Mr Jeffers and should have remained at the cell door until other staff arrived.

99. We note that Stocken did not have a local policy on dealing with blocked observation panels at the time of Mr Jeffers' death. Following his death, a Notice to Staff was issued in February 2021, which refers to the 2018 HMPPS Safety Briefing, and says that where an observation panel has been blocked and staff consider that a prisoner's life is in danger, they should 'summon assistance and remain at the cell continuing to try and gain a response while waiting for assistance to arrive'. However, we are very concerned that when we interviewed the officer in November 2021, he was unaware of the Notice to Staff issued in February.

100. We recommend:

The Governor should ensure that all staff are aware of the local policy on responding to blocked observation panels.

Clinical care

101. Mr Jeffers was under the care of mental health, substance misuse and primary care services. The clinical reviewer concluded that, overall, the clinical care Mr Jeffers received was equivalent to that he could have expected to receive in the community. Staff regularly reviewed him at Multi-Disciplinary Meetings and Multi-Professional Complex Case Meetings. Healthcare staff were routinely involved in ACCT case reviews. The GP did not allow Mr Jeffers to have his medication in possession again after the first overdose on 12 October.

102. As Mr Jeffers took an overdose of sertraline in October 2020 and had an excessive level of sertraline in his system at the time of his death, it is clear that he either obtained additional supplies illicitly within the prison or that he was not properly supervised when he collected his medication and so was able to stockpile it. Both scenarios are concerning.

103. The clinical reviewer noted that while Mr Jeffers was under the care of mental health services, he was not reviewed by the team psychiatrist. At the time, the psychiatrist was only available one day a week, but availability has now been increased to two days a week. Mr Jeffers' mental health keyworker said that if Mr Jeffers had still been alive, it was likely he would have been referred for a psychiatric assessment for his self-harming behaviour. If a psychiatrist was not available at that time, we consider there would have been a case for involving a psychologist when Mr Jeffers was being managed under enhanced ACCT procedures to provide advice on how to manage his prolific self-harming.

104. From October 2020, Mr Jeffers engaged with a counselling service provided by the prison. The information the counsellors obtained was not routinely shared with healthcare staff and they did not contribute to ACCT reviews. We make the following recommendation:

The Governor and Head of Healthcare should work with Safer Custody to establish joint information sharing from, and to, the counselling service to ensure that any relevant findings are available to key members of staff.

Supporting staff following a death in custody

105. Healthcare staff were not on duty at the time of Mr Jeffers' death, but some had been very involved in his care, particularly an agency nurse. She was not debriefed about his death or offered any support. One of the first officers at the scene also felt unsupported. We make the following recommendation:

The Governor and Head of Healthcare should ensure all staff who had significant involvement with any prisoner who dies in custody are offered support.

Family Liaison

106. PSI 64/2011 says that following a death in custody, the prison's family liaison officer should visit the next of kin in person to tell them and that this should be done quickly to ensure that the family does not find out from another source. However, Mr Jeffers died during a national COVID-19 lockdown and at the time, prisons were advised to inform next of kin by telephone. The guidance says that the call should be made as soon as possible after the death.

107. Mr Jeffers died at around 9.19pm on 25 November. An officer was not appointed as family liaison officer until the next day. He noted that he was unsure whether Mr Jeffers' family had been notified of his death. When he visited them later that day, they told him the police had visited them in the early hours of the morning.

108. We are concerned that there is no record that the police were asked to visit Mr Jeffers' family to break the news of his death and that the officer was unaware of this. It is also unclear why there was a delay in appointing a family liaison officer and why he took the decision to visit the family when the guidance in force at the time was to telephone. We recommend:

The Governor should ensure that a family liaison officer is appointed as soon as possible following a death in custody and that decisions around how and when the family should be notified are properly recorded.

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