Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Potter, a prisoner at HMP Stocken, on 30 March 2021

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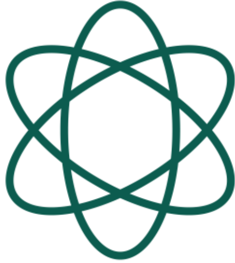
Our vision

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

OGL

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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 Mark Potter was found hanged in his cell at HMP Stocken on 30 March 2021. He was 29 years old. I offer my condolences to his family and friends.

Mr Potter had a history of mental health and substance misuse problems. I am concerned that when he told a mental health nurse that he heard voices telling him to kill himself daily, the nurse did not start suicide and self-harm prevention procedures, known as ACCT, and did not share this information with prison staff.

There were also unacceptable delays in the mental health team assessing Mr Potter, record keeping was poor and there was a lack of communication between mental health staff.

Mr Potter had significant drug debts which staff were not aware of. I am concerned that, following the suspension of the key worker system during the pandemic, staff had very little meaningful contact with Mr Potter and that this would have limited his opportunities to disclose his concerns.

I am also concerned that the defibrillator, taken to the emergency when Mr Potter was found hanged in his cell, was not working. It would not have affected the outcome for Mr Potter as he had rigor mortis when he was found, but in another emergency, this could be critical.

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 **March 2022**

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Summary

Events

1. In November 2019, Mr Mark Potter was remanded to prison at HMP Durham, charged with wounding and having a weapon in a public place. He had a significant history of mental ill health and substance misuse and was prescribed medication for depression. It was not his first time in prison.

2. In July, Mr Potter told staff he was being bullied and he was moved to the Vulnerable Prisoners wing.

3. In August 2020, Mr Potter was convicted and sentenced to seven years in prison. On 30 November, he was transferred to HMP Stocken. When he arrived, staff had no concerns about him, noted he was prescribed mirtazapine, an antidepressant, and referred him to the prison GP.

4. A GP saw Mr Potter on 13 January 2021 after he complained of anxiety and paranoia. The GP changed his medication and referred him to the mental health team for assessment.

5. The mental health team did not assess Mr Potter until 22 March when he denied thoughts of self-harm. He said that he saw shadows and heard voices telling him to kill himself daily. The nurse suggested that Mr Potter would benefit from antipsychotics and referred him for a psychiatric assessment.

6. A nurse prescriber tried to see Mr Potter on 28 March, but he was apparently not available. His appointment was rescheduled for 2 April.

7. On the morning of 30 March, an officer could not get a response from Mr Potter during a roll count. He radioed a medical emergency code at 7.16am and another officer responded swiftly. The officers entered the cell and found Mr Potter hanged in his cell. Staff cut the ligature and started cardiopulmonary resuscitation (CPR). They stopped shortly afterwards as Mr Potter displayed clear signs of rigor mortis.

8. At around 7.46am, paramedics arrived at Mr Potter's cell and, at 9.30am, a prison GP certified Mr Potter's death.

Findings

Assessment of risk

9. Mr Potter had a number of significant risk factors for suicide and self-harm, including a history of mental health and substance misuse issues, he was prescribed medication for depression and was considered vulnerable.

10. Mr Potter told staff at Durham that he was being bullied and was moved to the Vulnerable Prisoners' wing as a result.

11. After Mr Potter's death, it became clear that he had significant drug debts (which his mother was trying to pay off). He did not disclose this to staff at Stocken. We cannot say whether he might have felt able to do so if staff had had more meaningful contact with him during his time there.

12. When Mr Potter told a mental health nurse that he heard voices on a daily basis, telling him to kill himself, the nurse should have started suicide and self-harm prevention procedures, known as ACCT, and shared this information with prison staff.

Emergency equipment and resuscitation attempt

13. While we understand that staff wanted to try to save Mr Potter's life, rigor mortis was present when he was found, indicating that he had been dead for some hours and that resuscitation attempts would be futile. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased and should not be attempted.

14. We are concerned that the defibrillator brought to the emergency was unusable as it did not have any pads. This did not affect the outcome for Mr Potter as he had rigor mortis but, in another emergency, this could be critical.

Clinical care

15. The clinical reviewer raised concerns about mental health services at Stocken. She found that some areas of the mental healthcare provided to Mr Potter were not equivalent to that which he could have expected to receive in the community.

16. Mr Potter's mental health assessments were not carried out in a timely manner, and ACCT monitoring should have been considered when Mr Potter disclosed suicidal thoughts five days before his death. A mental health nurse also failed to record full details of his interaction with Mr Potter.

Recommendations

- The Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that staff:
  - receive ACCT training, including refresher training;
  - take into account all relevant risk information about prisoners when assessing their risk of suicide and self-harm and start ACCT procedures when appropriate; and
  - share important information about a prisoner's risk of suicide and self-harm with prison staff.
- The Head of Healthcare should share this report with Nurse C and discuss the Ombudsman's findings with him.
- The Governor should ensure that the security team share information about prisoners' risk factors with wing staff.

- The Governor should ensure that there is a clear process by which families and friends can raise concerns about a prisoner's wellbeing, and that such calls are monitored, recorded and followed up.
- The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate in line with European Resuscitation Council Guidelines.
- The Governor and the Head of Healthcare should ensure that all medical equipment is checked as a matter of urgency and systems put in place for ongoing monitoring.
- The Head of Healthcare should remind staff of the need to follow up any concerns about an individual's mental health and to refer prisoners to relevant support services.
- The Head of Healthcare should share this report with Nurse A and discuss the Ombudsman's findings with her.
- The Head of Healthcare should ensure that:
    - record keeping is regularly audited, and that staff are reminded about the need for quality entries in the SystmOne medical records;
    - immediately review the operational procedures of the mental health team, including putting in place clear decision-making protocols for staff roles, case allocation and timings; and
    - immediately implement a system to ensure that prisoners on the mental healthcare patient list continue to be monitored despite staff absences.
- The Head of Healthcare should share this report with Nurse B and discuss the Ombudsman's findings with him.
- The relevant NHS Commissioner should review the adequacy of mental health services at Stocken.

The Investigation Process

17. 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.

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

19. The investigator interviewed 11 members of staff at Stocken from May 2021. NHS England commissioned a clinical reviewer to review Mr Potter's clinical care at the prison, and the clinical reviewer joined the investigator for the interviews. All the interviews were conducted by telephone and video link because of the COVID-19 restrictions.

20. 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 him a copy of this report.

21. The Ombudsman's family liaison officer contacted Mr Potter's family to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Potter's family said that he had told the prison that he was being "tortured", but he did not say by whom. Mr Potter's mother said she had contacted the prison around two weeks before his death to raise concerns about him but received no response.

22. Mr Potter's family received a copy of the initial report. They did not make any comments.

23. The initial report was shared with HM Prison and Probation Service (HMPPS). They identified a number of inaccuracies which have been amended in the report. All recommendations were accepted.

Background Information

HMP Stocken

24. HMP Stocken is a category C prison in Rutland which holds up to 1059 men. Practice Plus Group provides healthcare services. Mental health services are delivered by Practice Plus Group, the healthcare provider. 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

25. The most recent inspection of HMP Stocken was carried out 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).

26. 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

27. 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 2020, the IMB remained concerned that the mental health team was under-staffed and that this had an impact on the mental health provision at Stocken.

Previous deaths

28. Mr Potter's was the third self-inflicted death at Stocken since January 2019. In a previous investigation into a self-inflicted death, we raised concerns about the mental healthcare provision. In September 2019, the Head of healthcare told us in response that the problems we had identified – a mental health assessment by an unqualified practitioner, an unjustified interruption in service and the absence of an individualised care plan and risk assessment – had all been resolved.

Psychoactive Substances (PS)

29. Psychoactive substances are a significant problem across the prison estate. They are difficult to detect and can affect people in a number of ways, including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. PS may also precipitate or exacerbate the deterioration of mental health and increase the risk of suicide or self-harm.

Key Events

HMP Durham

30. On 20 November 2019, Mr Mark Potter was remanded to HMP Durham, charged with wounding and having a weapon in a public place. It was not his first time in prison.

31. During his reception screen, staff noted Mr Potter's history of substance misuse and drug-related psychosis. He declined substance misuse support. He said that he had had contact with community mental health services and had been prescribed olanzapine, an antipsychotic, and sertraline, an antidepressant, but he had not brought any medication with him to prison. He said he had spent time in a psychiatric hospital and had tried to take his life two years earlier, although he said he had no current thoughts of self-harm.

32. The reception nurse referred him to the prison GP and the mental health team. They obtained his community medical summary which confirmed his history of psychosis, that he had spent a substantial period of time in a psychiatric hospital but that he was not under the care of a community mental health team and had not recently been prescribed any medication.

33. In December, the mental health team assessed Mr Potter's mental health. He said that he had anxiety and was not sleeping well. He said he had taken medication overdoses in December 2018 and April 2019. A prison GP noted that Mr Potter displayed no evidence of psychosis or depression and had no suicidal thoughts. He noted Mr Potter was anxious and prescribed sertraline.

34. A prison GP saw Mr Potter again on 21 February 2020. Mr Potter said his medication was not helping and he had problems sleeping. The GP noted no signs of psychosis and increased his sertraline dosage. The GP noted that the healthcare team had not yet been able to obtain Mr Potter's medical information about his psychiatric hospital admission and discharge.

35. In March, all prisons introduced a restricted regime in response to the COVID-19 pandemic, and, as a result, prisoners had less time out of cell and face-to-face visits and classes ended. As part of Durham's enhanced welfare checks during the pandemic, prison staff regularly spoke to Mr Potter who was generally recorded as being in good spirits and keeping in touch with his family.

36. In June, Mr Potter reported that he continued to hear voices and felt anxious and paranoid. He said that he had previously been told that his psychosis was a result of substance misuse, but he denied using drugs in prison. A prison GP increased his sertraline dose.

37. In July, Mr Potter told staff that he was being bullied and pressured by other prisoners to pay debts he did not owe. He said he had been assaulted numerous times. An investigation followed and Mr Potter was subsequently moved to the Vulnerable Prisoners (VP) wing.

38. A prison GP reviewed Mr Potter's medication on 5 August as Mr Potter said that his anxiety had worsened, and he was not sleeping. The GP planned to reduce his medication over a four-week period and prescribe a new medication, as well as a seven-day course of promethazine to help him sleep.

39. On 12 August, Mr Potter was sentenced to seven years in prison.

40. On 26 August, the prison psychiatrist saw Mr Potter who said that he was hearing voices and seeing shadows, and that he felt anxious and had stopped taking his sertraline. The psychiatrist changed his medication to mirtazapine, another antidepressant, and referred him to psychological services. The mental health team were again asked to obtain Mr Potter's medical records. The psychiatrist recorded that Mr Potter displayed no evidence of psychosis but that he had "mixed anxiety and depression" and residual symptoms of drug-induced psychosis.

41. Prison records indicate that Mr Potter was assaulted on 30 June and it was alleged that he may be the victim of bullying. Prison staff investigated this, but no information is recorded about the outcome.

42. On 16 November, a mental health nurse saw Mr Potter. He denied thoughts of suicide or self-harm and said he was taking his medication. He said he had felt mentally stable for six months and agreed that he could be discharged from the mental health team's caseload.

HMP Stocken

43. On 30 November, Mr Potter was transferred to HMP Stocken. His person escort record noted that he could be violent, had a history of concealing drugs and weapons and had been a victim of bullying. Prison staff at Stocken completed Mr Potter's reception screen. It was noted he had no thoughts of suicide or self-harm and no mental health issues. He was deemed unsuitable to share a cell.

44. A nurse completed Mr Potter's initial health screen. She noted that he was prescribed mirtazapine. Mr Potter said that he had a history of substance misuse. She noted his history of mental health problems, including anxiety. Mr Potter declined to see the mental health team but said he wanted to see the prison GP. He said he had never harmed himself and denied thoughts of suicide or self-harm. Mr Potter was deemed fit to keep his prescribed medication in his possession. The nurse described Mr Potter's mental health as stable and noted that he engaged well.

45. The following day, a prison GP continued Mr Potter's mirtazapine prescription. She planned to see Mr Potter in the New Year to discuss his medication.

46. On 2 December, an officer saw Mr Potter and completed a key worker session. He noted that Mr Potter appeared to have settled well at Stocken.

47. On 14 December, Nurse A completed Mr Potter's secondary health screen, 14 days after his initial screen. Mr Potter told Nurse A that he had frequent mood changes and was troubled by repeated thoughts, feelings and nightmares. He denied having experienced depression, although he did say that he had been in

hospital for non-medical reasons. Nurse A did not explore Mr Potter's comments. Mr Potter declined to see the substance misuse team.

2021

48. On 5 January 2021, prison security intelligence reports noted that four prisoners were found under the influence of an illicit substance. Mr Potter was suspected of being involved in supplying drugs to the prisoners.

49. On 8 January, Mr Potter made an application to see a GP. He said that his medication was not working and that he had anxiety and paranoia. A prison GP brought forward Mr Potter's appointment of 18 January to 13 January.

50. Mr Potter told the GP that he did not like being out of his cell. He described his experiences of drug-induced paranoia when he thought that the Government was controlling his mind and that people were watching him. He said he had been detained under the Mental Health Act on three occasions. He said he had not used illicit substances in prison. He said that he had felt suicidal in the past due to drug-induced psychosis. The GP noted that Mr Potter displayed no evidence of feeling low and that he denied current suicidal thoughts. In her entry in Mr Potter's electronic medical records, the GP questioned whether Mr Potter's paranoia was "more a symptom of anxiety". She changed Mr Potter's medication to citalopram, an antidepressant, and recorded that she felt that this may help with Mr Potter's sleep issues. She referred Mr Potter to the mental health and substance misuse teams.

51. On 19 January, a substance misuse worker saw Mr Potter, who denied taking illicit substances in prison. He said he was "feeling clear headed". The following day, during a key worker session, Mr Potter denied any current involvement in drugs.

52. On 28 January, 'Spice', an illicit psychoactive substance (PS), was found in Mr Potter's cell during a search and, on 30 January, Mr Potter was suspected to be under the influence of drugs. On 31 January, a prison security intelligence report noted that Mr Potter had been observed running around the wing during his regime time and also made two short phone calls. The security team listened to Mr Potter's phone calls and found that Mr Potter's mother was arranging to clear his debts for Spice.

53. On 1 February, a substance misuse worker saw Mr Potter as he had recently been seen under the influence. Mr Potter said he had used PS as he expected his relationship with his girlfriend to end and wanted to be "out of it for a few hours". He said he had no intention of using PS again. The worker gave Mr Potter information about the risks of using illicit substances.

54. On 5 February, Nurse B, a mental health nurse and nurse prescriber, recorded that the mental health team had received an application from Mr Potter who had wanted to be prescribed sleeping tablets. He was placed on the waiting list for the mental health triage team.

55. A few days later, a prison GP reviewed Mr Potter who said his sleep had worsened and he was sometimes awake for up to 48 hours and had resorted to

using Spice. She advised him against illicit substance use. She noted that she had no concerns about him. She agreed to prescribe him an increased dose of mirtazapine and advised him to see the mental health team if his mental state worsened.

56. On 26 February, a prison GP noted that Mr Potter was still waiting for his mental health triage appointment.

57. Further security intelligence reports dated 1 March suggested that Mr Potter was involved in suspicious activities linked to drug supply and debt collection.

58. When a substance misuse worker saw Mr Potter on 3 March, he told her that he had occasionally used Spice since February but no longer had insomnia after being prescribed mirtazapine. She discussed a comprehensive plan with Mr Potter, covering sleep hygiene, spice awareness, harm minimisation and taking responsibility.

59. At a key worker session on 11 March, Mr Potter said he kept in contact with his mother and sister, and the officer noted that he communicated well and that his cell was clean and tidy.

60. On 15 March, security intelligence reports noted that Mr Potter may be involved in money laundering activities.

61. On 22 March, Nurse C, a mental health nurse, completed Mr Potter's mental health assessment. Mr Potter told the nurse that he was "seeing shadows in front of him and voices telling him to kill himself" daily, and this caused him distress. He said he had had a similar experience in 2019 and was prescribed olanzapine, which had helped. Mr Potter talked about his numerous admissions to psychiatric hospitals. Nurse C told us at interview that, Mr Potter displayed "no overt psychotic depressive symptoms" during the assessment and was not presenting in a manner which would suggest that he was experiencing any of the symptoms that he had described. He recorded that Mr Potter said that he had no thoughts of self-harm.

62. In his notes, Nurse C noted on two occasions in the electronic records that a GP letter dated 22 November 2019 had been obtained. The investigator asked to see this letter and was given an undated GP summary. This document referred to Mr Potter's history of psychosis, auditory hallucinations, drug-related psychosis, cannabis misuse and depression. It also noted that he had been prescribed olanzapine in February 2015.

63. Nurse C told us that he did not start ACCT procedures or discuss Mr Potter with prison staff as he considered he was not at 'immediate or significant risk'. Instead, he considered that Mr Potter would benefit from being prescribed olanzapine. He referred Mr Potter to be assessed by Nurse B, the nurse prescriber, or the prison psychiatrist. He did not discuss Mr Potter with Nurse B.

64. On 28 March, Nurse B tried to see Mr Potter. He noted in Mr Potter's electronic medical record, "Indirect. Unable to see, exercise. Appointment rebooked". He told the investigator that he could not remember what happened and was unable to clarify what the entry 'indirect' meant. He said that he would 'probably not'

have discussed Mr Potter with wing staff. He rebooked Mr Potter's appointment for 2 April.

65. An Operational Support Grade (OSG) completed the evening roll check at around 8.30pm on 29 March and raised no concerns about Mr Potter.

30 March 2021

66. At around 5.10am, the OSG started the morning roll count on M Wing, Mr Potter's wing. CCTV footage shows that he used a torch to shine through the cell door observation panels to check on occupants. He said that when he arrived at Mr Potter's cell, he saw him lying in his bed.

67. The OSG completed a handover to Officer A when he started his duty at around 7.00am.

68. Officer A then started a roll check of the wing. At 7.15am, he looked through the observation panel and saw that Mr Potter was not in his bed. He then noticed Mr Potter's arm hanging from behind the curtain covering the window at the back of the cell. No other part of Mr Potter's body could be seen. He thought something was wrong and tried to get a response from Mr Potter by banging on the cell door. As Mr Potter did not respond, he radioed a medical emergency code blue (used to indicate a prisoner is unconscious or having difficulty breathing). The control room log recorded that this was at 7.16am. Staff in the control room called an ambulance and the prison healthcare team immediately.

69. CCTV shows Officer B responded to the emergency call and arrived at Mr Potter's cell within 45 seconds. Both officers unlocked and entered the cell. Officer B drew the curtain back and saw Mr Potter hanging by a ligature, made from a ripped bed sheet, attached to the window. Officer A supported Mr Potter's body whilst his colleague used his cut-down tool to cut the ligature. Mr Potter was then placed on the floor and Officer B started cardiopulmonary resuscitation (CPR). At interview, both officers said that Mr Potter showed no signs of life and his whole body, including his jaw, was stiff, an indication that rigor mortis was present.

70. Within 90 seconds, additional staff responded to the emergency. Officer C assisted with CPR. Due to the lack of space, a Custodial Manager instructed the staff to move Mr Potter onto the wing landing to continue CPR. An officer had obtained a defibrillator from the staff office and brought this to the landing, but it could not be used as the chest pads were missing. Officer C continued with CPR until healthcare staff arrived.

71. At 7.20am, a nurse and a pharmacy technician arrived on the wing landing, with the emergency resuscitation bag. The nurse told us that an officer had asked her to get a defibrillator which she had collected. She immediately assessed that Mr Potter had been dead for some time. She said that Mr Potter had no signs of life, his body was cold, his airway was blocked, and rigor mortis was present. She told the officers to stop resuscitation attempts as these were futile. Prison staff moved Mr Potter's body back into his cell.

72. At 7.46am, ambulance paramedic staff attended the scene and agreed with the nurse’s assessment. At 9.30am, a prison GP pronounced Mr Potter dead.

Post-mortem report

73. The post-mortem examination found that Mr Potter’s died from hanging. No illicit substances were detected in Mr Potter’s body.

Contact with Mr Potter’s family

74. Mr Potter’s mother was identified as his next of kin. Due to the COVID-19 restrictions, the police visited her at 8.25am and broke the news of Mr Potter’s death on the prison’s behalf.

75. A prison offender manager and a chaplaincy team member were appointed as family liaison officers. The offender manager spoke to Mr Potter’s mother at 2,30pm and offered his condolences and support. Stocken offered to contribute to the cost of Mr Potter’s funeral in line with national instructions.

Support for prisoners and staff

76. After Mr Potter’s death, the Head of Operations debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. All staff involved in the emergency response told the investigator that they felt well supported.

77. The prison posted notices informing other prisoners of Mr Potter’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 Potter’s death.

Other information discovered after Mr Potter’s death

78. After Mr Potter’s death, staff listened to phone calls he had made on 28 March. Mr Potter spoke to his mother twice. Much of their conversation was about how much debt Mr Potter had and details of how and when his mother was to settle these debts. One of the telephone numbers that Mr Potter gave his mother belonged to another prisoner at Stocken.

79. In addition, through the monitoring of PIN phones, a security intelligence report noted that another prisoner at Stocken phoned a family member in the hours after Mr Potter’s death and talked about money and paying money into a bank account. The prisoner referred to a telephone number that belonged to Mr Potter’s mother. Subsequent intelligence reports suggested that Mr Potter’s mother had been paying £400 a week to clear his debts.

Findings

Assessment and Management of risk

80. Prison Service Instruction (PSI) 64/2011 on safer custody and PSI 07/2015 on early days in custody list risk factors and potential triggers for suicide and self-harm. Mr Potter had a number of these risks when he arrived at Stocken: he had a significant history of mental ill health and substance misuse issues, he was prescribed medication for depression and was considered vulnerable. However, Mr Potter gave staff no indication that he was at imminent risk of suicide or self-harm when he arrived at Stocken and there was no immediate reason to monitor him under ACCT procedures at that point.

81. However, during a mental health assessment eight days before his death, Mr Potter described hearing voices telling him to kill himself. While we recognise that Mr Potter said he had no thoughts of self-harm, we consider that these suicidal comments should have alerted Nurse C to Mr Potter's increased risk of suicide, and he should have considered starting ACCT procedures. We also consider that he should have shared this information with prison staff.

82. 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 be balanced against how the prisoner presents. Given Mr Potter's mental health history, we consider that his risk of suicide and self-harm was elevated. We also note that Nurse C had not been trained in ACCT procedures, although he was aware of them.

83. We make the following recommendations:

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

    - **receive ACCT training, including refresher training;**
    - **take into account all relevant risk information about prisoners when assessing their risk of suicide and self-harm and start ACCT procedures when appropriate; and**
    - **share important information about a prisoner's risk of suicide and self-harm with prison staff**.

    The Head of Healthcare should share this report with Nurse C and discuss the Ombudsman's findings with him.

Mr Potter's drug and debt issues

84. When he was at Durham, Mr Potter told staff he was being bullied and he was moved to the VP wing. Mr Potter had never reported to staff that he was in debt

or that he feared for his safety due to his drug debts at Stocken and there is no evidence that wing staff were aware that he was in debt.

85. We are concerned that staff had very little meaningful interaction with Mr Potter during his four months at Stocken. The key worker system (under which prisoners have regular conversations with a dedicated officer) was suspended across the prison estate during the COVID-19 pandemic and, instead, Mr Potter had four sessions with three different officers: two in December 2020; a more meaningful one in January 2021 at which drugs were discussed; and one in March, a few weeks before his death at which nothing significant was discussed.

86. We recognise the difficulties that prisons have been operating under during the pandemic, but we consider that Mr Potter might have able to tell staff about his drug debts if he had been having more regular and consistent contact with them.

87. We are also concerned that, although wing staff do not appear to have known about Mr Potter's drug debts, the prison's security team knew from the end of January that he was in debt. Being in debt would have put Mr Potter at risk of bullying and the security team should have passed this information on so that consideration could be given to putting support in place for him.

88. After his death, Mr Potter's family said that they had contacted the prison by phone in the weeks before his death as they were concerned about him. Stocken told us there was no record of this. If Mr Potter's family did contact the prison, this should have been recorded and acted upon. However, while we have no reason to disbelieve the family, there is no hard evidence on which we could make a finding.

89. We recommend:

The Governor should ensure that the security team share information about prisoners' risk factors with wing staff.

The Governor should ensure that there is a clear process by which families and friends can raise concerns about a prisoner's wellbeing, and that such calls are monitored, recorded and followed up.

Emergency resuscitation attempt and equipment

90. NHS England's guidance to staff on when not to perform cardiopulmonary resuscitation is in line with the European Resuscitation Council Guidelines which state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile".

91. Officer B, who began chest compressions, assisted by Officer A and Officer C, were aware that Mr Potter showed no signs of life and had rigor mortis. When the nurse arrived and examined Mr Potter, she appropriately told staff to stop CPR as he was clearly dead.

92. We recognise that prison staff may want to attempt resuscitation until death has been formally recognised but they should understand that they should not do so

if someone is clearly dead. This is distressing for staff and undignified for the deceased. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate, in line with European Resuscitation Council Guidelines.

93. While it would not have made a difference to the outcome for Mr Potter, we are concerned that the chest pads for the defibrillator brought to the emergency were missing, which meant that it did not work. The custodial manager told us that it was the wing manager's responsibility to check the defibrillator equipment but said that there was no specific guidance in place to record the outcome of the checks. We therefore make the following recommendation:

The Governor and the Head of Healthcare should ensure that all medical equipment is checked as a matter of urgency and systems put in place for ongoing monitoring.

Clinical care

94. The clinical reviewer considered that the clinical care that Mr Potter received was of a good standard and equivalent to that which he could have expected to receive in the community. However, she found that some areas of the mental healthcare provided to Mr Potter at Stocken were not equivalent to that which he could have expected to receive in the community.

Mental health care

95. Overall, the clinical reviewer said that the mental healthcare provision at Stocken seemed chaotic, with assessments being delayed and little attention paid to risk. She concluded that staff resources appeared inadequate and those in post appeared to be unsupported and that Stocken relied on agency staff. The clinical reviewer made a number of recommendations which the Head of Healthcare will need to address.

Initial and secondary health screens

96. The clinical reviewer said that when Mr Potter arrived at Stocken, both his initial and secondary health screens were comprehensive. However, his second health screening took place 14 days after his arrival. National Institute for Health and Care Excellence (NICE) guidelines on the physical health of prisoners say that a secondary health screen to review potential long-term health conditions should be offered within seven days of arriving at prison.

97. The Head of Healthcare told us that Mr Potter's second reception screen was delayed because he had to isolate in his cell for 14 days after arrival due to COVID-19 restrictions. While this is a reasonable response, we are aware that there are a number of prisons which have completed initial and secondary health screen simultaneously during COVID-19 pandemic. Stocken may wish to consider this approach.

98. During his secondary health screen, Mr Potter said that he had frequent mood changes and admitted to being troubled by repeated thoughts, feelings and nightmares. He also said that he had been hospitalised for non-medical reasons. We consider that this should have raised concern and prompted a discussion from the nurse and consideration of a referral to the mental health team. However, this did not happen. We make the following recommendations:

The Head of Healthcare should remind staff of the need to follow up any concerns about an individual's mental health and to refer prisoners to relevant support services.

The Head of Healthcare should share this report with Nurse A and discuss the Ombudsman's findings with her.

Mental health appointment and assessment

99. A prison GP first referred Mr Potter to the mental health team on 13 January 2021. Mr Potter then made an application to see the mental health team on 5 February. After this, she reviewed Mr Potter twice (on 8 and 26 February) and noted that he was still awaiting his mental health assessment. Nurse C subsequently assessed Mr Potter on 22 March, eight days before his death and more than two months after the GP's referral.

100. We consider that the delay in assessing Mr Potter was significant, unacceptable and did not meet the requirements of the Prison Mental Health Services Specification 2018, which requires that urgent assessments take place within 48 hours and routine assessments within five working days.

101. After seeing Mr Potter, Nurse C referred him for assessment by Nurse B or the prison psychiatrist. Nurse B worked from Friday to Sunday, and he arranged to see Mr Potter on Sunday 28 March, six days after Nurse C's referral. We were told that there was no one available at Stocken to assess Mr Potter before this.

102. Nurse B made what appeared to be an unsuccessful attempt to see Mr Potter on 28 March. His entry in Mr Potter's medical record about this lacked detail and clarity, and, although he told us that he had met Mr Potter, his entry did not mention this. The clinical reviewer said that healthcare colleagues would have found it difficult to understand what, if any, interactions took place from Nurse B's entry. She noted that this fell short of the Nursing and Midwifery Council's record-keeping standards as Nurse B did not record his conversations with or observations of Mr Potter.

103. Nurse B rescheduled his appointment with Mr Potter for 2 April, six days later. There is no evidence that he considered asking another colleague to assess Mr Potter in the intervening days. Given Mr Potter's mental health history and the content of Nurse C's assessment, we consider that steps should have been taken for Mr Potter to be seen urgently, and that the delay was unacceptable. We note that GPs are on duty every day at Stocken, and a discussion or urgent referral could have been facilitated. Nurse B told us that the timeframes are dependent on staff availability.

104. Mental health team meetings were held once a week and the psychiatrist attended. However, the team meetings were always held on Nurse B's non-working day. We were told that Nurse B completed a template before the team meeting, detailing his input on cases which the team would discuss and action in his absence. This meant that he was never able to provide or clarify any additional concerns or information about his contact with patients to his colleagues in a live setting. He was unable to pass on any details about his lack of contact with Mr Potter. This way of working prevents continuity of care for patients.

105. We make the following recommendations:

The Head of Healthcare should:

- **ensure that record keeping is regularly audited, and that staff are reminded about the need for quality entries in the SystmOne medical records;**
- **immediately review the operational procedures of the mental health team, including putting in place clear decision-making protocols for staff roles, case allocation and timings; and**
- **immediately implement a system to ensure that prisoners on the mental healthcare patient list continue to be monitored despite staff absences.**

The Head of Healthcare should share this report with Nurse B and discuss the Ombudsman's findings with him.

106. Given the numbers of concerns about mental healthcare identified in this report, we recommend:

The relevant NHS Commissioner should review the adequacy of mental health services at Stocken.

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