Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Damien Price, a prisoner at HMP Swaleside, on 2 December 2021

A report by the Prisons and Probation Ombudsman

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Our vision

To carry out independent investigations to make custody and community supervision safer and fairer

Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

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 Damien Price died in hospital of a hypoxic brain and cardiac injury on 2 December 2021 after he was found hanging in his cell at HMP Swaleside two days earlier. He was 31 years old. I offer my condolences to his family and friends.

Mr Price was autistic and found it difficult to cope in prison. He had a history of self-harm and had last been monitored under suicide and self-harm prevention procedures (known as ACCT) in October 2021. However, I am concerned that ACCT monitoring stopped when Mr Price still had significant risk factors and before all the actions in his ACCT care plan had been completed. In the weeks before his death, Mr Price had become more settled.

I am concerned that Mr Price did not receive his medication on 30 November as he requested, and we consider that this was likely a significant contributory factor to Mr Price's decision to take his life.

I am also concerned about aspects of the emergency response: there was a delay in prison staff entering Mr Price's cell after they found that he had blocked his cell door observation panel and a delay in the ambulance entering the prison.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Kimberley Bingham
Acting Prisons and Probation Ombudsman **January 2023**

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Summary

Events

1. On 14 March 2020, Mr Damien Price was remanded into custody at HMP Exeter. It was his first time in prison. After sentencing, on 25 January 2021, he was transferred to HMP Swaleside as part of his sentence progression. Mr Price had autism, a personality disorder, and a history of self-harm. He had been monitored under suicide and self-harm prevention procedures, known as ACCT, in prison, most recently two weeks before his death.

2. On 30 November, Mr Price told staff that he had not received his medication. Despite the night duty nurse's efforts to dispense it, Mr Price did not receive it. That evening, officers found Mr Price hanging in his cell, with a ligature tied around his neck. Staff and paramedics responded promptly and recovered a heartbeat. He was transferred to hospital but died on 2 December.

3. Post-mortem and toxicology test results showed that Mr Price died from a hypoxic brain and cardiac injury caused by hanging. Post-mortem toxicology tests results indicated therapeutic levels of fentanyl (an opiate painkiller) and lamotrigine (a drug prescribed for epilepsy and psychosis) in Mr Price's system.

Findings

4. In October 2021, staff appropriately started ACCT procedures but stopped them prematurely, while Mr Price still had significant risk factors and before actions in his care plan had been completed. However, in the days before his death, we consider that Mr Price presented with no new known risk factors for suicide and self-harm, and we consider that staff reasonably concluded that he did not need ACCT monitoring at that time.

5. On 30 November, Mr Price asked for his medication, but he did not receive it. We consider that his missed medication had a significant impact on him and had most likely triggered his actions that day.

6. He told his brother that an officer had told other prisoners that he was a 'grass' because he had thrown a kettle at him. Mr Price said that as a result of this, other prisoners were coming to his cell door and he could not go anywhere.

7. Mr Price also alleged that staff at Swaleside had targeted him. There is little evidence to explain what Mr Price meant and we found no substantive evidence that this was the case. However, staff should be mindful of how their comments and actions are perceived by prisoners.

8. There was a delay in staff checking on Mr Price's wellbeing when they found that he had blocked his cell door observation panel.

9. We are concerned that there was a five-minute delay before the ambulance was able enter the prison.

10. The clinical reviewer concluded that the care that Mr Price received at Swaleside, considering the complexity of his needs, was of a standard equivalent to that which he could have expected to receive in the community. However, she was concerned about the time it took for a psychiatrist to see Mr Price, delays in receiving treatment, delays in prescribing and monitoring medication compliance and the need for better communication between healthcare staff and other psychological services.

Recommendations

- **The Governor should ensure that staff manage prisoners identified as at risk of suicide or self-harm in line with national instructions, including that:**
    - **staff consider all current and future risk factors and triggers when they consider stopping ACCT monitoring procedures; and**
    - **care plans are specific, meaningful, tailored to the individual to reduce their risk and completed before ACCT monitoring is stopped.**
- **The Governor, Head of Healthcare and Head of Pharmacy should ensure that:**
    - **when changes are made to the location of medication, it should be communicated to all healthcare staff so that both day and night duty staff are aware;**
    - **when prisoners do not collect their medication, a reason for their non-attendance is recorded; and**
    - **procedures are in place to ensure that prisoners, who are unable to collect their medication through no fault of their own, are given it, including at their cell door, if necessary.**
- **NHS England should ensure that when HMP Swaleside's contract for health services is next renewed the healthcare provider is contracted to provide additional staffing levels to ensure that mediation hatches and treatment rooms on A Wing and D Wing are staffed by healthcare professionals in line with current practice on the other of Swaleside's wings.**
- **The Governor and Head of Healthcare should ensure that staff consider all relevant risk information about prisoners when assessing their risk of suicide and self-harm and start ACCT procedures when appropriate.**
- **The Governor should ensure that:**
    - **staff identify information about bullying, in all its forms, and fully and promptly investigate it, where necessary;**
    - **alleged perpetrators are appropriately challenged; and**

- **victims are effectively supported and the possible impact on their risk of suicide and self-harm properly considered and addressed.**

- **The Governor should ensure that:**

    - **a local protocol is developed and shared with staff to instruct them on what to do if they find a cell observation panel obscured at any time of day; and**

    - **subject to a risk assessment and in line with PSI 64/2011, staff enter cells as quickly as possible if there is reason to consider that a prisoner may be at risk.**

- **The Governor should ensure that:**

    - **officers understand the importance of communicating the details of a medical emergency as quickly as possible;**

    - **control room staff call an ambulance as soon as they receive a medical emergency code; and**

    - **there are no delays in ambulances being given access to the prison.**

- **The Governor and Head of Healthcare should ensure that a copy of this report is shared with all staff named in this report so that they are aware of the Ombudsman's findings.**

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Swaleside informing them of the investigation and asking anyone with relevant information to contact him. Several prisoners asked to speak to the investigator.

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

13. NHS England commissioned a clinical reviewer to review Mr Price's clinical care at the prison.

14. The investigator interviewed thirteen members of staff and seven prisoners at Swaleside. All the interviews were conducted remotely due to the restrictions imposed as a result of the COVID-19 pandemic.

15. We informed HM Coroner for Mid Kent and Medway of the investigation. She provided us with a copy of the post-mortem and toxicology reports. We have sent her a copy of this report.

16. We contacted Mr Price's family to explain the investigation and to ask if they had any matters that they wanted us to consider. They asked if Mr Price was subject to ACCT monitoring at the time of the incident, about his contact with and the support he received from the prison's mental health team, if he might have been bullied and about the circumstances leading to his death. These concerns are addressed in this report and in the clinical review.

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

Background Information

HMP Swaleside

18. HMP Swaleside, on the Isle of Sheppey, is part of the long-term high security estate. It holds up to 1,090 men serving sentences of at least four years. At the time of Mr Price's death, Integrated Care 24 provided primary healthcare. There is 24-hour nursing cover. Oxleas NHS Foundation Trust provided mental health services. In April 2022, Oxleas took over all healthcare provision at Swaleside.

HM Inspectorate of Prisons

19. HMIP carried out a full inspection of Swaleside in October 2021. Inspectors reported that overall outcomes for prisoners at the prison remained disappointing but noted that senior managers and staff were doing their best to take the prison forward. However, inspectors reported that low-level poor behaviour went unchallenged, they found too many staff in offices, away from the prisoners in their care, and noted a lack of visible input from middle managers to support staff and reinforce standards and practices.

20. Inspectors reported that the quality of ACCT monitoring was variable in quality, with inconsistent case management and care plans that lacked meaningful or completed actions. Inspectors reported that there were too few work and vocational options available to prisoners and that staff shortages had a negative impact on the regime offered.

21. Inspectors noted that progress against previous PPO recommendations had not been fully embedded into practice, including ensuring quality ACCT care plans.

22. Inspectors reported that some emergency resuscitation equipment had not been kept in good order and that it was unclear if it was regularly checked. Inspectors reported that the method of transporting medicines to the wings was unsafe, that aspects of medicine management were poor and some risk assessments for permitting prisoners to keep and administer their medication had not been updated when circumstances changed. Inspectors also reported that the lack of prescription charts and the administration of medicines at cell doors were inappropriate and unsafe.

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 ending April 2021, the IMB reported on a lack of meaningful activity due to COVID-19. The IMB reported that medication was dispensed on some wings which eased the strain on prisoners being taken to the healthcare centre. However, the IMB reported that medications were often delayed, which caused frustration to staff and prisoners, and it required improvement.

Previous deaths at HMP Swaleside

24. Mr Price was the third prisoner to take his life at Swaleside since January 2020. There are no similarities between our findings in this investigation and our investigation into a prisoner who died in July 2021. In our report into the death of a prisoner in October 2021, we raised issues about prisoners receiving their medication, an issue we also address in this report.

25. There were also seven deaths from natural causes at Swaleside during this period. There were no significant similarities between our findings in these investigations and our findings in this report.

Assessment, Care in Custody and Teamwork

26. 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 prisoners. As part of the process, a care plan which includes support and intervention should be in place. The ACCT plan should not be closed until all the care plan actions have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 on safer custody.

Key Events

Background

27. On 14 March 2020, Mr Price was remanded into custody at HMP Exeter, charged with actual bodily harm and of endangering life. He had autism and a dissocial personality disorder.

28. In October, Mr Price was transferred to HMP Bristol. The mental health and crisis teams supported him, offered psychosocial interventions, and prescribed antidepressants. He had sensory processing difficulties: he was hypersensitive to noise so was given ear defenders, he was sensitive to physical contact, he found breaks in routine difficult and he found groups of people threatening.

29. On 15 December, Mr Price was sentenced to six and a half years in prison, and Bristol planned to transfer him to Swaleside as part of his sentence progression.

30. On 24 January 2021, Bristol provided a handover to Swaleside's safer custody team and outlined the adjustments that Mr Price needed, including his need for ear defenders, regular access to the library and a set routine.

HMP Swaleside

31. On 25 January, Mr Price was transferred to Swaleside, where the mental health team saw him. Mr Price was discussed at a safeguarding meeting, and it was decided that Supervising Officer (SO) A would be his main point of contact and that a psychologist would meet him weekly.

32. It was noted that Mr Price had not been referred to Swaleside's Pathways Unit, a psychologically-informed, planned environment (PIPE) as he did not meet the unit's criteria and there was a waiting list. (The Pathways Unit aims to address offenders' behaviour to help them progress in completing sentence plans. The aim is for prisoners to maintain their own and others' safety while improving their psychological, social, and physical wellbeing.) It was noted that the PIPE may benefit Mr Price in the future.

33. On 17 February, it was noted that Mr Price had settled but spent most of the time in his cell due to noise levels on the wing. A few days later, Mr Price was moved to a quieter area of the wing and it was noted that he had settled. On 25 February, he was discussed at a multidisciplinary (MDT) safeguarding meeting.

34. On 25 March, Mr Price told the psychologist that he struggled with a lack of routine and meaningful activity. The following day, he was prescribed mirtazapine, an antidepressant. On 30 March, he was discussed at a multidisciplinary care plan approach (CPA) meeting, held with all those involved in a patient's mental healthcare to discuss their needs and review mental health care plans.

35. On 16 April, Mr Price told the psychologist that he had stopped taking his antidepressants. She told him that she would discuss with a prison psychiatrist if a mood stabilizer might be more suitable. On 19 May, the psychiatrist prescribed Mr Price lamotrigine, a mood stabiliser. On 17 June, he told the psychologist that he

had not noticed a difference since taking it. (The psychiatrist increased the dosage on 14 July.)

36. On 21 June, Officer A introduced himself to Mr Price as his keyworker.

37. At a CPA meeting on 3 August, Mr Price's suitability for the Mulberry Unit, a specialist unit at HMP Wakefield that provides services for prisoners with autism, was discussed.

38. On 29 August, a SO challenged Mr Price about his aggressive behaviour. He became violent and barricaded his cell door. Prison staff later found that he had made several ligatures. He was monitored under ACCT procedures.

39. On 31 August, Mr Price told an officer from the safer custody team that he had not received his medication for six weeks, and that this was a possible cause for his recent behaviour. The following day, the officer told the Head of Healthcare that Mr Price had not received his medication.

40. On 10 September, Mr Price told the psychologist that he felt stressed, continued to struggle with noise and had not heard about his referral to the Mulberry Unit. Several days later, he asked if he could move to the Pathways Unit.

41. On 20 and 21 September, Mr Price blocked his cell observation panel and assaulted staff when they tried to enter his cell. The following day, Mr Price said that he had assaulted staff because they had targeted him and were not making adjustments for him.

42. On 23 September, a neurodiversity support manager spoke to Mr Price and referred him to the Swaleside Outreach Service (SOS, a partnership service between HM Prison and Probation Service and Oxleas NHS Foundation Trust, run by prison staff, psychologists and clinicians to help prisoners whose behaviour is complex, challenging, violent and/or disruptive). She reminded staff about Mr Price's triggers, coping strategies and how best to support him and noted that a move to the Pathways Unit would unsettle him.

43. At an MDT meeting on 27 September, staff involved in Mr Price's care discussed his disruptive behaviour. He was told that his referral to SOS and the Mulberry Unit was ongoing. It was agreed that a 'know your resident' fact sheet would be started to give officers the information to support Mr Price effectively.

44. On 29 September, Mr Price told the psychologist that he believed that nothing would change, despite the recent MDT meeting, as many of his triggers were environmental and outside of his control.

45. On 7 October, Mr Price told the psychologist that he had not eaten for several days, he felt let down by the justice system and said, "I don't want to die but I'm ready to die." Mr Price told Ms Gadsden that he was not taking his mood stabiliser and they discussed the possibility of starting antidepressants, but Mr Price said that they had not helped in the past. Staff started ACCT monitoring procedures, a food refusal log and healthcare staff assessed him.

46. During an ACCT assessment on 8 October, Mr Price said that he wanted to be dead but talked positively about life after prison. He said that he got on well with a

prisoner peer mentor from the prison's community mentor scheme, as well as other prisoners who kept an 'eye out' for him. Mr Price asked for just one member of staff to interact with him during the day.

47. At an ACCT review on 11 October, Mr Price told staff that he was eating again but complained about the number of observations he was subject to. He said that he felt hopeless and that it affected his autism when officers did not do what they said they would do. The ACCT care plan was updated to note that Mr Price's referral to SOS and the Pathways Unit and his need for new ear defenders should be followed up. Mr Price said that it was pointless being subject to ACCT monitoring. It was explained to him that monitoring would continue until the care plan actions had been completed.

48. On 14 October, the psychologist noted that Mr Price's mood had improved and that he was more positive about the future. He was told that he had been referred to the Pathways Unit and for an SOS assessment.

49. At an ACCT review on 18 October, Mr Price expressed frustration that only some staff let him help with wing jobs and took him to the library. It was noted that a plan would be put in place for wing staff to know how to manage his needs. (This action was not noted in his ACCT care plan.)

50. That evening, Mr Price blocked his observation panel, an officer tried to get a response from him but when the officer opened the cell door, Mr Price threw a kettle of boiling water at him.

51. On 19 October, during a prison lockdown, Mr Price pushed past officers when they opened his door to give him his lunch and officers used force to return him to his cell. Shortly afterwards, Mr Price blocked his observation panel, barricaded his cell door, and tied a ligature around his neck. Staff went into the cell and cut him down. He was moved to the healthcare centre and put under constant observation.

52. At an ACCT review, Mr Price said that he would hang himself until he had killed himself or someone else and would not eat or take his medication. Mr Price said that he felt that he had been treated harshly and wanted to return to his own wing.

53. On 20 October, at an ACCT review, Mr Price said that he continued to have suicidal thoughts and was keen to move to the Pathways Unit. He was told that he would first need to be assessed by SOS, given his unsettled behaviour. The SOS assessment remained outstanding. Mr Price was told that there had also been no response from the Mulberry Unit.

54. The psychiatrist reviewed Mr Price to decide if he needed antidepressants. He noted that Mr Price appeared relaxed and there was no evidence of psychosis or anxiety. He prescribed quetiapine, an antipsychotic, for emotional dysregulation.

55. At an ACCT review on 22 October, Mr Price said that he had wanted to be dead and that the next time he had a 'meltdown', he would try to hang himself again. It was noted that staff should not bang on his cell door when carrying out ACCT checks unless they could not see him or had concerns.

56. That day, a systemic psychotherapist from the PIPE, told a nurse that Mr Price would not be assessed to see if he was suitable for the Pathway Unit until early

November. (He was subsequently assessed, although it is not clear when. It was considered that Mr Price was not suitable for Pathways due to his recent violence. Prisoners' behaviour had to be stable for at least three months before they were eligible to access the PIPE programme.)

57. On 27 October, a SO told a registered forensic psychologist that Mr Price's suitability for the Mulberry Unit had not yet been considered as the lead was on leave. She asked an officer for an update about his SOS referral.

58. On 28 October, Mr Price told the psychologist that he had responded well to his antipsychotics and asked for his mood stabiliser to be dispensed later in the day. Mr Price said noise levels had improved and he had mixed more with others.

59. On 29 October, Mr Price's SOS assessment was completed. Triggers relating to Mr Price's risks were identified, including that he felt unsupported and that he was being lied to. It was assessed that his risk to himself had increased significantly and that he no longer felt scared about hanging himself.

60. The assessment concluded that Mr Price should continue to receive mental health and SOS support, and that an MDT approach would be helpful.

61. On 1 November, Mr Price told SO A at an ACCT review that he had not been in a good place but that playing chess helped to distract him. Although Mr Price's risk of suicide and self-harm was considered low, ACCT monitoring remained in place.

62. At an ACCT review on 8 November, it was noted that Mr Price was waiting to be moved to the Pathways Unit and that there was a waiting list for the Mulberry Unit. The psychologist later noted that Mr Price continued to struggle with noise levels and still needed new ear defenders. They noted that Mr Price was due to attend court in Exeter on 24 November.

63. On 9 November, Mr Price attended the SOS day centre and library, and appeared in better spirits. Mr Price discussed his need for new headphones which he could plug into his television. The neurodiversity support manager was contacted for an update about their availability. An officer emailed the registered forensic psychologist and a SO to reiterate that an MDT approach would be helpful for Mr Price.

64. On 11 November, Mr Price told an officer that he struggled with the music from his neighbours' cell. His concerns were reported to the supervising officer on the wing and the officer noted that she would contact the neurodiversity team.

65. On 12 November, the psychologist noted that Mr Price was relaxed but continued to struggle with noise levels, to the extent that he had said that he would kill himself. She reassured Mr Price that the issues were being addressed and noted that his statements were likely driven by frustration and anger. Mr Price told her that he had a tendency to internalise and ruminate on things rather than talk about them, and that these thoughts often led to impulsive actions.

66. Mr Price told her that SOS activities, keywork sessions and better-timed welfare checks would help. The psychologist fed back to a SO, who agreed to see what the wing could put in place for him and noted that the safer custody team would be

sharing with wing staff the care plan that Mr Price had in place at Bristol. The psychologist told the SO that it might be helpful to review the plan with Mr Price.

67. On 13 November, SO A noted that Mr Price did not appear to be in a 'good place' but that his mood had improved.

68. On 15 November, Mr Price told an officer that if he was sent to Exeter for his court hearing and saw the prison staff who had 'assaulted' him, he would assault them.

69. At an ACCT review on 16 November, Mr Price said that he had had a 'wobble' the previous day due to wing noise and added that if he had not been taken to SOS, he would have harmed himself. Mr Price said that his ear defenders did not prevent him hearing the noise of bass music, that prisoners who played loud music were not being dealt with and that he had not received his new earphones. It was noted that an officer would chase them up. They also discussed Mr Price's court hearing on 24 November. He made it clear that he did not want to return to Exeter and threatened to harm others.

70. The review team ended his ACCT monitoring. They noted that he had denied thoughts of self-harm. However, SO A noted that Ms Hemsworth had raised concerns about stopping ACCT procedures as Mr Price had expressed thoughts of self-harm the previous day. They noted that Mr Price would be best managed through a wing management plan rather than through ACCT procedures and that the SOS team would liaise with the Pathways Unit so that Mr Price could visit. The psychologist noted that Mr Price's move to the Pathways Unit was to be put on hold until a decision about the Mulberry Unit had been made. An MDT meeting was arranged for 7 December.

71. On 19 November, Mr Price told the psychologist that an officer on the wing had been unhelpful and that had SO A not talked things through with him, things might have 'ended up differently'. She told him that it was positive that he could recognise how he felt.

72. That day, the Mulberry Unit confirmed that Mr Price's referral had been considered from a clinical perspective, it had been passed to the operational team to review and that they would be in contact.

73. On 20 November, it was noted that Mr Price had chatted to staff when he collected his lunch. He had been upset during the afternoon but had calmed down after talking to staff. Mr Price asked a nurse what medication he had been given.

74. At an SOS meeting on 22 November, it was agreed that Mr Price would benefit from further clinical engagement and was allocated a trainee forensic psychologist.

75. At an ACCT post-closure review on 23 November, it was decided that ACCT procedures should remain closed. Mr Price said that noise levels had improved, he continued to work with the SOS team and denied thoughts of self-harm. The psychologist later noted that it would be helpful for wing staff to know Mr Price's triggers and warning signs, to have a 'know your resident' fact sheet and to introduce a 'traffic light system' so that he could tell staff how he felt.

76. On 25 November, the psychologist met Mr Price for the last time. They discussed noise levels and the benefits of engaging with the SOS team. She noted that their

next session should focus on making Mr Price's feelings and emotions more visual for himself and wing staff.

77. On 26 November, Mr Price spoke to his brother by telephone and seemed positive and upbeat. He told his brother how an officer had told other prisoners that he was a 'grass' because he had thrown a kettle at him. Mr Price said that as a result of this, other prisoners were coming to his cell door and he could not go anywhere. Mr Price said that he had been shown the Pathways Unit which he said would not be a good place for him, that he had been told that he was too violent to go to the Mulberry Unit but not violent enough to go to the Pathways Unit. Mr Price talked at length about his mental health, medication, and his court case.

78. On 29 November, Mr Price went to the library, he took part in a quiz and went to the SOS day centre. Mr Price told prison staff he had had a few bad days. They told him that he could ask to attend SOS for respite.

79. A prisoner who lived in the cell opposite Mr Price said that Mr Price was quite upset in the three days leading to his death. He said that he appeared fine after he had been taken to the library.

80. During the week of 29 November, the dispensing of medication at prisoners' cells was stopped in response to a Care Quality Commission (CQC) recommendation following an HMIP inspection. This meant that prisoners had to attend the healthcare centre instead to collect their medication.

Events of 30 November

81. On the morning of 30 November, D Wing was in lockdown due to a COVID-19 outbreak and prisoners spent the day in their cells while the wing was tested. SO B, the wing manager, contacted healthcare staff and made efforts to arrange for all prisoners to be given their medication at their cell doors as no movement was permitted. He said that healthcare staff were reluctant to do so. He said that he made staff and CM (Custodial Manager) A, the duty manager in charge of the prison, aware of the situation. (CM A said that he was not aware that D Wing had been locked down, that Mr Price had not received his medication. He said that he had not had any conversations with healthcare staff about prisoners receiving their medication.)

82. SO B said that he was not told what arrangements had been made for the morning dispensation of medication to prisoners as staff were busy carrying out COVID-19 tests. However, he said that he was told that prisoners would be escorted to the healthcare centre to collect their medication and that prisoners who refused to have a COVID-19 test, or tested positive for COVID-19, would be given their medication at their cell doors. He said that he was not aware that Mr Price had not received his medication that day.

83. At some point that day, a nurse noted on Mr Price's medication dispensing charts that he had not attended the healthcare centre for his medication.

84. A prisoner who lived in the cell opposite Mr Price said that he appeared fine during the day. Two other prisoners who lived in the cell next to Mr Price, said that he seemed okay. One said said that between around 5.00pm and 6.00pm, he heard

Mr Price shout out once or twice about not getting his medication. Another said that Mr Price had rung his cell bell and shouted that he needed his medication.

85. At 7.43pm, Mr Price rang his cell bell. Officer A said that Mr Price asked for his medication and asked why it had been missed. She spoke to the Head of Healthcare, who said that Mr Price should have picked his medication from the healthcare centre and would now have to wait until the following day for it. She told Mr Price what the Head of Healthcare had said. Mr Price was not happy but told him not to worry.

86. Officer A contacted the control room to speak to the duty manager but was told by an unidentified officer that if healthcare staff had said that Mr Price would have to wait until the following day, there was nothing that could be done. She said that Mr Price had not blocked his observation panel at this point.

87. An officer said that Mr Price's medication issue was discussed at the handover at around 8.00pm. Another officer said that there was a handover at around 8.30pm but that he could not recall anything being discussed about Mr Price's medication.

88. At around 8.20pm, an Operational Support Grade (OSG) arrived on the wing and received a handover from Officer A. She told him that Mr Price had asked about his medication and about her contact with the Head of Healthcare and a CM. Officer A said that the OSG told her that he would do all he could to get Mr Price his medication as it was unacceptable for him to wait until the following day. The OSG said that he believed Officer A told him that Mr Price had blocked his observation panel but had had a verbal response from Mr Price.

89. A prisoner said that at around 8.30pm, he heard banging sounds from Mr Price's cell and had assumed that Mr Price might have damaged something. Another prisoner said that he heard banging from Mr Price's cell at around 8.15pm and thought furniture might have been being moved before he heard a 'crash', and it then went quiet.

90. The night nurse arrived in the healthcare centre at around 8.45pm and received a handover from the day nurse, whom he said told him that all the medications had been dispensed. He said that Mr Price was not mentioned. The day nurse said that she would have given the night nurse a handover but said that prisoners who did not collect their daily medication would not have been discussed.

91. During the evening roll check at around 8.45pm, the OSG found that Mr Price had blocked his observation panel. Mr Price refused to remove the blockage. (He said that at this point, he did not know if Mr Price had barricaded his cell.) He said that Mr Price, who was very angry, told him that he had not received his medication during the day. He told Mr Price that he would find out from healthcare staff what had happened.

92. The CM said that at around 8.45pm, the OSG told her that Mr Price had not received his medication and was agitated. She said that this was the first time that she knew of the issue and that it had not been mentioned during CM A's handover. The CM said that she told the OSG that he should wait for the healthcare handover to be completed, which was normally done between 8.45pm and 9.00pm and

should then speak to the night nurse about it. The CM said that she could not recall the OSG telling her that Mr Price had blocked his observation panel.

93. At around 9.00pm, the OSG told the night nurse that Mr Price had not received his medication. He told the OSG that as far as he was aware, all wing medications had been dispensed but he would check to see whether Mr Price had received his medication.

94. The OSG said he recalled that the night nurse told him that healthcare staff had been expecting Mr Price to collect his medication but that he never came. The OSG explained to the nurse that Mr Price would not have been able to collect his medication because the wing was in lockdown due to COVID-19 testing and Mr Price was in his cell as he refused to be tested. (He said that the usual procedure was for Mr Price to collect his medication on the wing every night and that he did not know what had changed that day.)

95. The OSG told the CM that he had contacted healthcare staff about Mr Price's medication. He said that the CM told him that if the healthcare centre could not give Mr Price his medication, there was nothing more they could do. He said that he believed that he told the CM that Mr Price had blocked his observation panel.

96. That evening, the Head of Safety and Equalities visited D Wing with the CM. The OSG told them that he had been in contact with healthcare staff to tell them that Mr Price had not yet received his medication and agreed that it could be taken to his cell door once found.

97. At around 9.39pm, the OSG went to Mr Price's cell to explain that the nurse was checking to see why he had not received his medication. He said that Mr Price did not respond and although the observation panel remained blocked, he could see Mr Price's shadow moving. He said that Mr Price wore ear defenders so might not have heard him. He used his torch but there was still no response, so he assumed that Mr Price did not want to speak to him.

98. The night nurse checked Mr Price's medical records and confirmed that he had not been given his medication which he had been due at 8.00pm.

99. Officer B, who was in the operations room, said that she spoke to the OSG, who told her that Mr Price had not received his medication. She said that this was the first time that she had heard about the medication issue and that Mr Price had blocked his observation panel. She spoke to the CM, who told her to call the night nurse for an update. The nurse confirmed that Mr Price had not received his medication and that he needed to go to D Wing for it. The officer then told the OSG that the nurse and officers would give Mr Price his medication on the wing.

100. At around 9.50pm, three officers went to collect the nurse from the healthcare centre and made their way to C Wing, where the medications for D Wing were kept. However, when the nurse arrived on the wing, he was unable to find Mr Price's medication and assumed that it was not in stock. The nurse told the officers that he would explain the situation to Mr Price.

101. At around 9.58pm, the OSG went to Mr Price's cell door for a third time. He tried to tell Mr Price that the nurse was coming to give him his medication, but Mr Price did

not respond. He used his torch to look into the cell before he left at around 10.00pm and returned to the wing office.

102. At around 10.08pm, Officer C and the night nurse arrived at Mr Price's cell to tell him that they could not find his medication. Mr Price's cell's observation panel was blocked, and Mr Price did not respond to the officer's calls. The officer tried to shine his torch into the cell to see Mr Price, and seconds later, Officer B and another officer joined him. Officer B opened the door and found Mr Price hanging from the light fitting, with a ligature made from bedding, around his neck. She immediately called a medical emergency code blue (used when a prisoner is unresponsive or has breathing difficulties) at around 10.10pm.

103. Officer C and Officer D tried to enter the cell but could not do so as Mr Price had put a cabinet behind the cell door. The night nurse left to collect emergency medical equipment. At around 10.11pm, the officers managed to get into the cell. Officer D supported Mr Price while Officer C cut the ligature from around his neck.

104. The officers immediately started cardiopulmonary resuscitation (CPR). The night nurse returned with an emergency response bag. The nurse said that he found no signs of life and helped the officers with their resuscitation efforts. A defibrillator was attached but it advised no shock. Staff continued with their resuscitation attempts.

105. The ambulance log noted that the ambulance arrived at the prison at around 10.25pm. However, paramedics noted that there was no one to meet them at the gate and there was a five-minute delay before they got into the prison. The prison's vehicle log notes that paramedics were let into the prison at 10.30pm.

106. At around 10.34pm, paramedics arrived on the wing, and took over resuscitation attempts. They found a pulse and managed to stabilise Mr Price before he was taken to Medway Maritime Hospital at around 12.41am on 1 December and transferred to the intensive care unit. Mr Price was pronounced dead at 9.57am on 2 December.

107. A note was found in Mr Price's cell after his death. In the note, Mr Price said, "I have suffered at the hands of those that claim to want to keep us safe and I can stand it no longer. The hypocrisy, the corruption, the abuse. The inability to rehabilitate..." Mr Price also wrote about the love and support of his family and asked for their forgiveness.

Interviews with prisoners

108. A prison Insider (an experienced prisoner who welcomes new prisoners) and support mentor said that Mr Price was a quiet and complex prisoner. He, and another prisoner who also supported Mr Price, said that over time, they gained Mr Price's trust and said that Mr Price openly talked about death but did not talk about harming himself in the weeks before his death. The prisoners said that staff were considerate to Mr Price and did what they could for him. They raised no concerns about Mr Price having issues with officers.

109. A prisoner said that Mr Price got on well with other prisoners and never spoke to him about harming himself. Another prisoner said that Mr Price got on well with

most officers on the wing and although he 'would kick off' with some, officers were sympathetic.

110. A prisoner who lived on another spur on D Wing alleged that Officer C would sometimes antagonise Mr Price. Another prisoner said that several days before the incident, Mr Price had said that he was being targeted by Officer C, who would 'slam his observation flap', and another officer, but he had not seen this himself.

Contact with Mr Price's family

111. At around 10.34pm, the appointed family liaison officer told Mr Price's father that his son had been admitted to hospital having been found unresponsive in his cell and that his prognosis was poor. Members of Mr Price's family visited him in hospital later that day. Mr Price died at 9.57am on 2 December. Swaleside offered to contribute to funeral expenses in line with national instructions.

Support for prisoners and staff

112. A prison governor debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

113. The prison posted notices informing other prisoners of Mr Price's death and offered support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Price's death.

Post-mortem report

114. Mr Price's post-mortem report established that Mr Price died from a hypoxic brain and cardiac injury caused by hanging. Post-mortem toxicology tests results indicated therapeutic levels of fentanyl (an opiate painkiller) and lamotrigine (a drug prescribed for epilepsy and psychosis) in Mr Price's system. The clinical reviewer noted, from the available records, that Mr Price was not prescribed fentanyl as a routine medication but that the blood sample used for the toxicology tests was in a poor condition and may have been affected by extended storage before it was analysed.

Findings

ACCT monitoring

115. Prison Service Instruction (PSI) 64/2011 on safer custody requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and manage prisoners identified as at risk under ACCT procedures.

116. PSI 64/2011 says that case managers must complete care plans with actions aimed at reducing the risk of suicide and self-harm and that reflect the prisoner's needs. At Mr Price's first ACCT review on 11 October, it was noted that Mr Price needed new ear defenders. On 18 October, during an ACCT review, it was noted that a wing care plan should be put in place and shared with wing staff. This was not noted on the care plan. However, when ACCT monitoring stopped on 16 November, these actions had not been completed. The PSI makes it clear that ACCT procedures should not be stopped until all care plan actions have been completed.

117. At the ACCT review on 16 November, Mr Price's upcoming court appearance was discussed, and a SO raised concerns about ending ACCT monitoring because of Mr Price's comment the previous day about having thoughts of self-harm. However, SO A and others present considered that Mr Price was no longer in immediate crisis and the ACCT procedures were stopped.

118. We consider that ACCT monitoring ended prematurely as the care plan actions had not been completed, Mr Price had expressed thoughts of self-harm the previous day and concern about his court appearance the following week. We make the following recommendation:

The Governor should ensure that staff manage prisoners identified as at risk of suicide or self-harm in line with national instructions, including that:

- **staff consider all current and future risk factors and triggers when they consider stopping ACCT monitoring procedures; and**
- **care plans are specific, meaningful, tailored to the individual to reduce their risk and completed before ACCT monitoring is stopped.**

Access to medication on 30 November

119. On 27 to 28 November, healthcare staff prepared to dispense medication from the healthcare centre rather than D Wing following a recommendation from the CQC after an HMIP inspection. A serious incident report completed by Integrated Care 24 after Mr Price's death, noted that the change had led to resistance from prison staff, which meant that many prisoners were not escorted to the healthcare centre to collect their medication.

120. A nurse said that the Head of Healthcare had told healthcare staff not to dispense medication at prisoners' cell doors under any circumstances unless the prisoner had COVID-19 symptoms or needed supervised medication at night. She said that staff were told that if they were found dispensing medication at cell doors outside of

the new protocol, they would be asked to leave the prison. We understand that during this time, officers were given a list of prisoners who needed to be escorted to the healthcare centre for their medication.

121. On 30 November, Mr Price did not collect or receive his medication. We have been unable to ascertain why. It might have been because officers were not aware of the change in dispensing arrangements, that Mr Price was not on the medications list, that officers were not available or were unwilling to escort him, that he refused to leave his cell to collect it, or he was unable to leave his cell because it was in lockdown and he had refused to be tested for COVID-19.

122. Mr Price was agitated and upset that, despite asking for his medication, he did not receive it. The psychologist said that if there had been an issue about his medication, Mr Price would have wanted to know. We consider that Mr Price not receiving his medication was a likely trigger for his actions.

123. The night nurse said that he was not aware of and had not been told about the new plans in place to dispense medications. Had he known that the medication had moved to the healthcare centre, he could have accessed them and given them to Mr Price. However, it was his first week back after leave and he had not been told that they had been moved. This miscommunication is concerning.

124. That evening, officers on duty and the night nurse made every effort to arrange for Mr Price to receive his medication but they were unable to. We do not criticise their efforts. However, the issue played significantly on Mr Price's mind and was likely exacerbated by his autism. The clinical reviewer concluded that Mr Price's missed medication was the most likely trigger for his actions. We make the following recommendation:

The Governor, Head of Healthcare and Head of Pharmacy should ensure that:

- **When changes are made to the location of medication, it should be communicated to all healthcare staff so that both day and night duty staff are aware;**
- **when prisoners do not collect their medication, a reason for their non-attendance is recorded; and**
- **procedures are in place to ensure that prisoners, who are unable to collect their medication through no fault of their own, are given it, including at their cell door if necessary.**

125. The Governor of Swaleside told us that the ability to dispense medications on A and D Wings was an ongoing issue at Swaleside, and had been for several years, because the wings do not have dedicated medication hatches and treatment rooms. Although Swaleside have offered to provide rooms and infrastructure for medications to be dispensed on these wings, we understand that Oxleas and previous healthcare providers have been unable to provide staff to cover these facilities as contract specifications do not cover this. We make the following recommendation:

NHS England should ensure that when HMP Swaleside's contract for health services is next renewed the healthcare provider is contracted to provide additional staffing levels to ensure that mediation hatches and treatment rooms on A Wing and D Wing are staffed by healthcare professionals in line with current practice on the other of Swaleside's wings.

Assessment of Mr Price's risk

126. In the days before Mr Price's death, he did not display behaviour that would indicate that he was at a particular risk of suicide or self-harm, he presented with no new risk factors and he expressed no intention to self-harm. None of the prison staff or prisoners we spoke to considered that he was at an increased risk of suicide or self-harm in the weeks before his death.

127. ACCT monitoring is used to monitor people in crisis. Mr Price was clearly upset and frustrated about not receiving his medication on 30 November. With the benefit of hindsight, it is easy to conclude that given Mr Price's difficulties in accessing his medication and the impact of this on him, particularly in light of his autism, he should have been monitored under ACCT procedures. Starting ACCT monitoring would have led to an assessment and multidisciplinary review of his needs and the consideration of further safeguards. Although the lack of access to his medication is likely to have played significantly on his mind and might have contributed to his decision to take his life, we do not consider that his demeanour had changed or that his risk had increased significantly enough for staff to monitor him under ACCT procedures. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff consider all relevant risk information about prisoners when assessing their risk of suicide and self-harm and start ACCT procedures when appropriate

Allegations of bullying

128. Mr Price told his brother in a telephone call that an officer had called him a 'grass' which had resulted in other prisoners going to his cell door. There is no evidence that Mr Price complained to staff at Swaleside about this or about being bullied by specific members of staff. We accept that Mr Price had said that he was upset with officers from Exeter and Swaleside, whom he believed had treated him badly during and after confrontations and in failing to provide him with reasonable adjustments.

129. However, a prisoner who lived on another spur on D Wing alleged that Officer C would sometimes antagonise Mr Price. Another prisoner said that several days before the incident, Mr Price had said that he was being targeted by Officer C, who would 'slam his observation flap', and by another officer, but he had not seen this himself. However, other prisoners to whom we spoke did not indicate or provide any evidence that Mr Price might have been bullied.

130. Both officers denied the allegations against them. There is no evidence that Mr Price reported to staff that he was being bullied by other prisoners, although we accept that Mr Price might have perceived other prisoners playing loud music on the wing as a form of intimidation. We recognise that the prison environment can be challenging and unpleasant for many prisoners, particularly for those with

autism. Although we consider that it is unlikely that Mr Price took the action that he did on 30 November as a consequence of the allegations he made, prison staff should always be conscious of how their actions might be perceived by those in their care, particularly by those with mental health issues. We make the following recommendation:

The Governor should ensure that:

- **staff identify information about bullying, in all its forms, and fully and promptly investigate it, where necessary;**
- **alleged perpetrators are appropriately challenged; and**
- **victims are effectively supported and the possible impact on their risk of suicide and self-harm properly considered and addressed**

Blocking of observation panel and delay in entering cell

131. PSI 24/2011 says that under normal circumstances, cells must not be opened at night without the authority of the night manager and unless a minimum of two or three staff are present, depending on local policy. It goes on to say that the preservation of life must take precedence and where there is, or appears to be immediate danger to life, staff may enter cells on their own, subject to a rapid dynamic risk assessment of the situation. However, night staff should not take action that they feel would put themselves or others in unnecessary danger.

132. Swaleside does not have a local policy to tell staff what to do if they find a cell observation panel obscured. In such circumstances, we would expect staff who cannot see or speak to a prisoner to radio other staff for help and remain at the cell door. If they believe the prisoner may be at risk, they should assess the risk of opening the cell door themselves before help arrives. Our own expectation reflects that of senior managers at Swaleside.

133. Although the OSG was aware that Mr Price had blocked his observation panel when he started his shift and reported this to the night manager after his check at 8.45pm, no immediate actions were taken to check on Mr Price's welfare. It was not until officers went to Mr Price's cell to tell him about his medication that further intervention took place.

134. We recognise that it can be difficult for staff to make instant decisions in difficult and unknown circumstances. However, when there is a potentially life-threatening situation, it is essential that staff act quickly and exercise good judgement. We do not say that the OSG should have entered the cell on his own. However, we consider that when it became apparent that Mr Price had blocked his observation panel, especially as he was not responding, the OSG should have raised the alarm sooner and night managers should have acted with more urgency. It was not until around ten minutes later that they went into the cell, despite Mr Price's agitation that he had not received his medication.

135. We cannot say whether the delay in entering the cell affected the outcome for Mr Price. However, a delay of even a few minutes can make the difference between life and death in medical emergencies. We make the following recommendation:

The Governor should ensure that:

- **a local protocol is developed and shared with staff to instruct them on what to do if they find a cell observation panel obscured at any time of day; and**
- **subject to a risk assessment and in line with PSI 64/2011, staff enter cells as quickly as possible if there is reason to consider that a prisoner may be at risk**

Emergency response

136. PSI 03/2013 on medical emergency response codes requires staff to prevent any unnecessary delay in escorting ambulances and paramedics to the patient and discharging them from the prison. Swaleside's local guidance to staff reflects this.

137. However, there was a delay of around five minutes before paramedics were able to enter the prison. Any delay can have a significant impact on a prisoner's chance of survival. Given that staff and paramedics were able to establish Mr Price's pulse, we cannot know whether earlier intervention might have resulted in a different outcome for him. It is important that prison staff understand their roles in a medical emergency, and we make the following recommendation:

The Governor should ensure that:

- **officers understand the importance of communicating the details of a medical emergency as quickly as possible;**
- **control room staff call an ambulance as soon as they receive a medical emergency code; and**
- **there are no delays in ambulances being given access to the prison.**

Clinical care

138. The clinical reviewer concluded that overall, the clinical care that Mr Price received, considering the complexity of his needs, was of a standard equivalent to that which he could have expected to receive in the community.

139. However, the clinical reviewer identified several issues which the Head of Healthcare will need to address. These included that Mr Price was not able to see a psychiatrist urgently, there was a delay in him receiving recommended treatment, the length of time between prescribing and receiving medication was too slow and there was poor oversight of whether he was complying with his medication. The clinical reviewer also noted that Mr Price's assessments for additional support and transfer to a more suitable environment was too slow and resulted in delays, and communication between healthcare staff, the PIPE and SOS needed to improve.

Learning lessons

140. We consider that it is important for staff to learn from our findings. We therefore make the following recommendation:

The Governor and Head of Healthcare should ensure that a copy of this report is shared with all staff named in this report so that they are aware of the Ombudsman's findings.

Inquest verdict

141. The inquest into the death of Mr Price concluded on 7 November 2022. It confirmed that the medical cause of Mr Price's death was hypoxic brain and cardiac injury sustained from hanging. It concluded that Mr Price's death resulted from suicide and gave the following reasons for reaching this conclusion: Mr Price had left a suicide note, blocked his observation panel and cell door to restrict access and had a history of self-harm and suicide attempts. The inquest also noted that Mr Price had not received his medication on 30 November due to a failure of communication between prison and healthcare staff.

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