Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Aiden Jackson, a prisoner at HMP Gartree, on 20 September 2021

A report by the Prisons and Probation Ombudsman

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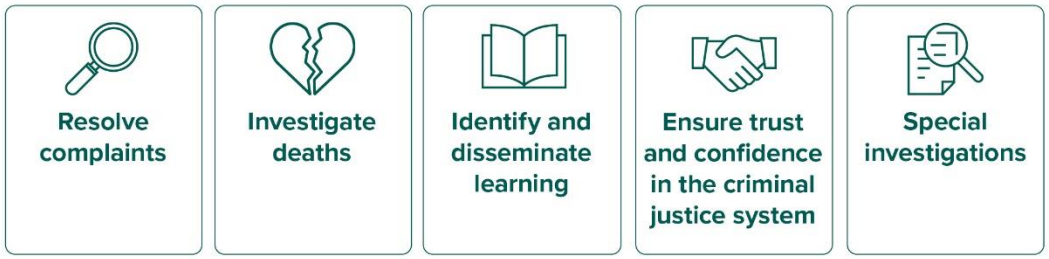
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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.

If my office is to best assist HM Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Aiden Jackson was found hanged in his cell on 20 September 2021 at HMP Gartree. He was 28 years old. I offer my condolences to Mr Jackson's family and friends.

Mr Jackson was a vulnerable man who had been in prison since he was 17 years old. His mental health and substance misuse issues meant he was monitored under Prison Service suicide and self-harm prevention measures (known as ACCT) on several occasions. My investigation found that the ACCT procedures provided good support to Mr Jackson.

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

Adrian Usher
Prisons and Probation Ombudsman **October 2023**

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Summary

Events

1. In October 2010, Mr Aiden Jackson was remanded to prison charged with murder. He was sentenced to life imprisonment in November 2011. Mr Jackson was 17 years old and was from the Traveller community. He had a history of attempted suicide, self-harm, mental illness and substance misuse. Mr Jackson had attention deficit hyperactivity disorder (ADHD) and did not always take his medication as prescribed.

2. Mr Jackson transferred to HMP Gartree in May 2016. He moved to the therapeutic community a few months later but decided to stop receiving therapy and returned to a standard wing in July 2019. He received support from the mental health team and substance misuse service after he told staff that he had been taking illicit substances.

3. Mr Jackson found it difficult to cope with the restricted regime implemented at the prison during the COVID-19 pandemic. He was managed under suicide and self-harm monitoring procedures (known as ACCT) between May and August 2020 after he threatened to harm himself and took an overdose.

4. Prison staff monitored Mr Jackson under ACCT procedures again between April and May 2021, after he told them that he had thoughts of suicide. During this period, the Parole Board decided that Mr Jackson was not suitable for open conditions (a Category D prison).

5. On 15 August, Mr Jackson told prison staff that he had taken an overdose and they began ACCT monitoring.

6. At 10.40pm, Mr Jackson's partner told prison staff that she was concerned that he was going to self-harm. A prison officer completed a welfare check but did not see Mr Jackson in his cell because he had covered his observation panel. He returned to Mr Jackson's cell at 11.40pm. The officer was unable to obtain a response from Mr Jackson and telephoned for assistance.

7. At 11.45pm, a custodial manager and an officer arrived and went into the cell. Mr Jackson was hanging from the window bars. They radioed a medical emergency code and started cardio-pulmonary resuscitation (CPR). Ambulance staff arrived at 12.05am, and at 12.19am they confirmed that Mr Jackson had died.

Findings

8. The ACCT procedures provided good support to Mr Jackson. Case reviews were multi-disciplinary and care map actions reflected his mental health and substance misuse needs. However, important information that would have helped to appropriately assess Mr Jackson's risk was not added to his ACCT document or entered onto his electronic prison record.

9. The officer who checked Mr Jackson the night he died did not take appropriate action when he found that Mr Jackson had covered his observation panel. He waited an hour before returning to Mr Jackson's cell and raising the alarm.

10. The clinical reviewer concluded that Mr Jackson's mental health and substance misuse care was equivalent to what he could have expected to receive in the community.

The Investigation Process

11. HMPPS notified us of Mr Jackson's death on 20 September 2021. The investigator issued notices to staff and prisoners at HMP Gartree informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

12. The investigator visited Gartree on 28 September 2021 and spoke to three prisoners. She obtained copies of relevant extracts from Mr Jackson's prison and medical records.

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

14. The investigator interviewed 10 members of staff at Gartree between November 2021 and April 2023. She and the clinical reviewer jointly interviewed healthcare staff.

15. We informed HM Coroner for Leicester City and South Leicestershire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

16. We wrote to Mr Jackson's father to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Jackson's father wanted to know the circumstances leading to Mr Jackson's death to understand why he had taken his life. We have addressed his questions in this report.

17. On 6 June 2023, the solicitor representing Mr Jackson's mother wrote to us and asked for a copy of our initial report.

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

19. Mr Jackson's mother received a copy of the initial report. The solicitor representing her wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

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

Background Information

HMP Gartree

21. HMP Gartree, which is near Market Harborough in Leicestershire, holds up to 700 men mainly sentenced to life imprisonment and other indeterminate sentences. Nottinghamshire Healthcare NHS Foundation Trust provides healthcare services at the prison. Nursing staff are available 24 hours a day.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Gartree was a scrutiny visit in September 2020. Inspectors reported that levels of self-harm had increased. Relations between staff and prisoners were good and most prisoners received key work sessions. Care for vulnerable prisoners was also reasonably good.

Independent Monitoring Board

23. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to November 2021, the IMB reported that over the past year, the safer custody and equality functions had benefitted from an additional resource, which had enabled the allocation of dedicated staff to lead on ACCT and/or Challenge, Support, and Intervention Plan (CSIP, the violence reduction process) reviews and documents.

Previous deaths at HMP Gartree

24. Mr Jackson was the tenth prisoner to die at Gartree since September 2018. Of the previous deaths, seven were from natural causes and two were self-inflicted. There have been ten deaths since: eight from natural causes, one self-inflicted death and one is awaiting classification.

25. In March 2021, we made a recommendation about the procedure for prison staff when an observation panel is covered. Gartree accepted our recommendation and said that guidance was reissued to all staff in May 2021. However, in a recent investigation into the death of a prisoner at Gartree in October 2022, we again found that staff had failed to take action when a prisoner had blocked his observation panel.

Assessment, Care in Custody and Teamwork (ACCT)

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 the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will

occur. Regular multidisciplinary review meetings involving the prisoner should be held.

Key Events

27. On 22 November 2010, Mr Aiden Jackson was remanded to prison charged with murder. He was 17 years old. In October 2011, he was convicted and sentenced to life in prison. This was Mr Jackson's first time in prison. Mr Jackson spent time in several prisons before moving to HMP Gartree on 10 May 2016.

28. Mr Jackson had a history of threatened and attempted suicide. He was under the care of the Child and Adolescent Mental Health Service and received counselling to manage his feelings of anger and difficulties with coping with his offence and sentence. Before he moved to Gartree, Mr Jackson was managed under Prison Service suicide and self-harm monitoring procedures (known as ACCT) on nine occasions after cutting himself, taking an overdose and threatening to harm himself.

29. Mr Jackson had a long history of substance misuse and had used illicit substances since he was a teenager. In 2015, while Mr Jackson was at HMP Dovegate, a psychiatrist assessed that he was displaying symptoms of Attention Deficit Hyperactivity Disorder (ADHD is a mental health condition that can cause unusual levels of hyperactivity and impulsive behaviour). The psychiatrist noted that Mr Jackson's treatment was not always consistent in the community, and he had stopped taking his prescribed ADHD medication before he came into prison. Mr Jackson was prescribed medication for ADHD in prison, but he did not always take it and healthcare staff were often unable to administer it because of his illicit drug use.

HMP Gartree

30. Mr Jackson arrived at Gartree on 10 May 2016. A nurse completed his initial health screen and noted that Mr Jackson was managed under ACCT in the last month but did not have any current thoughts of suicide or self-harm. A GP prescribed Mr Jackson methylphenidate (to treat ADHD symptoms), mirtazapine (antidepressant) and risperidone (anti-psychotic), which he was initially allowed to keep with him in his cell. Mr Jackson did not always take his medication as prescribed. He was referred to the substance misuse service (SMS) and mental health team. Mr Jackson told an SMS counsellor that he was regularly using psychoactive substances, cannabis and hooch (home brewed alcohol). He saw an SMS counsellor every three weeks until March 2017, when his counsellor left the prison, and he told SMS staff that he did not need further support.

31. In November 2016, Mr Jackson moved to the prison's therapeutic community (TC). The TC holds up to 25 prisoners and offers support and guidance to life sentenced prisoners who have learning difficulties. Mr Jackson made good progress in the TC. He did not share any thoughts of suicide or self-harm and there was no evidence that he was using illicit substances. Mr Jackson had no significant clinical issues while he was located in the TC.

32. In July 2019, Mr Jackson told prison staff that he wanted to stop receiving therapy and asked to leave the TC. He moved to a single cell on A wing, a standard residential wing. Mr Jackson was allocated a keyworker, who saw him regularly. During a meeting with his offender manager, Mr Jackson said that his decision to

leave the TC was a form of self-sabotage and he appeared unsettled and anxious. He refused support from the mental health team.

33. On 11 October, Mr Jackson told his keyworker that he was finding it difficult to settle on A wing and felt angry and disheartened. He denied any feelings of suicide and self-harm and he was encouraged to speak to TC staff if he needed emotional support. On 23 October, prison staff referred Mr Jackson to the SMS because they were concerned that he was using illicit substances. Mr Jackson told an SMS nurse he was using Subutex (a substitute for opioids) daily. He refused methadone (a synthetic opioid used to treat heroin addiction) but agreed to support from the mental health team. Prison staff submitted a security information report to enable staff to gather intelligence on the drugs activity at the prison.

34. A mental health review took place on 25 October with a mental health nurse. Mr Jackson said that he was hearing voices associated with his victim. The nurse noted that Mr Jackson did not have a diagnosis of schizophrenia and made a referral to the psychiatrist. Mr Jackson did not attend his appointment with the psychiatrist on 3 December.

35. Mr Jackson continued to receive support from the SMS. In January 2020, his urine tested positive for Subutex, and he agreed to start taking methadone. A GP prescribed 30mls daily, which was increased to 40mls shortly after. Mr Jackson's methadone dose was reduced to 10mls on 16 April. He remained on methadone until 18 June. SMS staff noted that Mr Jackson did not meet the eligibility criteria for the TC because of his behaviour.

36. On 23 March, a national lockdown was imposed due to the COVID-19 pandemic. Prison regimes were severely curtailed and face-to-face services were reduced or stopped. Key work was formally suspended across the prison estate on 24 March. Gartree continued to provide key work to prisoners who were subject to ACCT monitoring.

ACCT 29 May - 5 August 2020

37. Between 29 May and 5 August, Mr Jackson was managed under ACCT after he told staff he felt low and was threatening to harm himself. Prison staff added three actions to Mr Jackson's care plan, that he should continue to engage with the mental health team and substance misuse service and to take his prescribed medication. On 23 June, he took an overdose of his prescribed medication and drank one litre of hooch. Mr Jackson told staff that he was struggling with the restricted regime, but he did not intend to harm himself. Prison staff assessed his risk of suicide as raised and increased his observations to two every hour. A GP decided that Mr Jackson should no longer keep his prescribed medication in his possession.

38. Mr Jackson did not attend a psychiatrist appointment on 25 June. He received regular support from his keyworker and staff encouraged him to arrange video calls with his family. These took place throughout the COVID-19 restrictions.

39. Prison staff held regular multi-disciplinary ACCT case reviews. They reduced the frequency of Mr Jackson's observations when his risk of suicide and self-harm

decreased. Mr Jackson said that his sleep had improved, and he felt more positive. Staff encouraged him to apply for a job so he would spend more time out of his cell.

40. Staff agreed to stop ACCT monitoring on 5 August. Mr Jackson's risk of suicide and self-harm was assessed as low, and staff noted he was in regular contact with his family and would seek support if his mood deteriorated.

41. On 17 September, the psychiatrist assessed Mr Jackson and prescribed 80mgs of propranolol for anxiety. During October, Mr Jackson was found with hooch on two occasions and told the SMS that he was drinking to make himself feel better. Prison staff submitted security information reports on each occasion. A mental health assessment with a nurse on 25 October, noted that Mr Jackson did not have any current thoughts of suicide and self-harm. Mr Jackson's anxiety was related to his index offence, which caused him to struggle with sleeping. The nurse noted that Mr Jackson had problems with his partner, which had caused his anxiety to increase. Mr Jackson said that he understood that his non-compliance with his medication could impact on his hopes to move to a Category D prison.

42. In January 2021, Mr Jackson met with his prison offender manager to discuss his Parole Board hearing. Mr Jackson said he would consider applying for the PIPE unit (psychologically informed planned environments- residential units that support the progression of prisoners with complex needs and personality related difficulties). Mr Jackson was aware that he would only be eligible for the PIPE or TC if he had three months of stable behaviour on the wing. Mr Jackson was found in possession of hooch on two occasions during February and received warnings under the Incentives and Earned Privileges Scheme (IEPS).

43. During a meeting with his offender manager on 4 March, Mr Jackson was told that he was not considered suitable for Category D conditions and needed to take responsibility for his behaviour on the wing.

ACCT: 5 April-21 May 2021

44. On 5 April, staff started ACCT monitoring after Mr Jackson told an SMS worker he had thoughts of ending his life. Staff added three actions to Mr Jackson's care plan, which said he should continue to engage with the mental health team, substance misuse service and his prison offender manager. Prison staff decided he should be observed four times every hour. Mr Jackson told staff he felt anxious about his Parole Board hearing on 12 April because he had been in prison since he was 17 and did not know anything else. Staff carried out an ACCT assessment after the hearing and noted that Mr Jackson appeared low and did not make eye contact. Mr Jackson said the Parole Board hearing had gone well.

45. On 14 May, Mr Jackson's offender manager told him the Parole Board had recommended that he remain in closed conditions and his next hearing would take place in May 2022. Prison staff held a case review the same day. Mr Jackson said he was focused on maintaining his good behaviour, so he was eligible for the PIPE unit.

46. Staff held regular multi-disciplinary ACCT case reviews and reduced Mr Jackson's observations when his mood improved. Staff noted that he engaged well with the mental health nurse during case reviews. Mr Jackson said he did not have any

current thoughts of suicide and self-harm and was finding it easier to cope. He was helping another prisoner serving food which kept him busy, and he was looking forward to fewer restrictions on the wing.

47. Staff agreed to stop ACCT monitoring on 21 May. Mr Jackson had agreed to start taking his ADHD medication again and he had no current thoughts of suicide or self-harm. He felt settled on A wing and was in regular contact with his family. Mr Jackson was added to the mental health team caseload again (having previously refused their support) to monitor his ADHD.

48. Mr Jackson continued to receive support from the SMS to discuss his use of illicit substances and hooch. During a mental health team meeting on 12 July, staff noted that Mr Jackson did not always take his ADHD medication as he should.

ACCT 15 August-20 September

49. At approximately 2.40pm on 15 August, Mr Jackson told prison staff that at 12.30pm, he had taken an overdose of paracetamol, ibuprofen and naproxen (which was not prescribed to him). A nurse saw Mr Jackson immediately and noted his National Early Warning Score (NEWS - an assessment tool to identify acutely ill patients) was 1 (low clinical risk). She decided that based on the amount of medication Mr Jackson claimed to have taken, he should be transferred to hospital for further investigations.

50. At 2.45pm, a Supervising Officer (SO) started ACCT monitoring. He completed the immediate action plan and assessed Mr Jackson as high risk of suicide and self-harm. He decided that Mr Jackson should be monitored four times every hour.

51. At 3.10pm, a Custodial Manager (CM) told healthcare staff that Mr Jackson should remain at the prison until the blood test results were available. If Mr Jackson's condition deteriorated, he should be taken to hospital. Mr Jackson remained in the healthcare unit for observation. We are unable to interview the CM because he no longer works for the Prison Service.

52. At 4.45pm, a nurse recorded Mr Jackson's NEWS as 2 (low clinical risk). At 7.33pm, she noted that Mr Jackson's blood test results had not been received and noted that his NEWS was 1 (low clinical risk). She contacted TOXBASE (the clinical toxicology database of the National Poisons Information Service), who said the level of paracetamol in Mr Jackson's blood was 131 (plasma-paracetamol concentration in mg/litre) and he should be taken to hospital immediately. Mr Jackson went to hospital at approximately 8.45pm. Two prison officers escorted him, and he was restrained using an escort chain (a length of chain with handcuffs at each end). This was removed when Mr Jackson was admitted to hospital.

53. Hospital doctors treated Mr Jackson with acetylcysteine (an intravenous treatment for paracetamol overdose). Mr Jackson refused the third infusion and signed a disclaimer to that effect. He returned to Gartree at 11.10am on 16 August. Healthcare staff assessed Mr Jackson. He told healthcare staff that he was aware of the dangers of liver damage if he refused further treatment.

54. A SO completed an ACCT assessment at 2.45pm on 16 August with a nurse. Mr Jackson said he had taken the tablets because he had difficulty sleeping and had

not intended to harm himself. He made minimal eye contact and said he was more scared of living than dying. The SO added one action to Mr Jackson's care plan, which said that Mr Jackson needed an urgent mental health assessment and a psychiatrist appointment. His level of risk and observations remained unchanged.

55. Staff held multi-disciplinary ACCT reviews every two days until 23 August. Mr Jackson was assessed as high risk and he continued to be observed four times every hour. Staff added three further actions to Mr Jackson's care plan, which said that healthcare should ensure Mr Jackson had a mental health assessment and prison staff should advise Mr Jackson about applying for enhanced status.

56. On 19 August, the Clinical Matron held a multi-disciplinary team meeting to discuss Mr Jackson's mental health treatment plan. She noted that Mr Jackson was not taking his ADHD medication as prescribed and should be seen by the psychiatrist. Mr Jackson had not been assessed by the mental health team and staff noted that his mental health caseworker had left the prison.

57. A SO held an ACCT review on 23 August with a mental health nurse. Mr Jackson engaged with the review and agreed to set an alarm so he could get up to take his medication. The SO encouraged Mr Jackson to apply for a job so he could spend more time out of his cell. He assessed Mr Jackson's risk as medium and reduced his observations to two every hour with two conversations a day.

58. The SO held an ACCT review on 30 August with a mental health nurse. He noted that healthcare staff would contact the wing every day to ensure Mr Jackson took his morning medication. Mr Jackson said he did not have any thoughts of suicide or self-harm and the SO assessed his risk as low. He reduced Mr Jackson's observations to one conversation in the morning and afternoon.

59. Mr Jackson did not attend his appointment with the psychiatrist on 2 September.

60. On 9 September, a SO held an interim ACCT review with a nurse because Mr Jackson's partner had telephoned the prison and expressed concerns that Mr Jackson was going to self-harm. Mr Jackson refused to engage and said that he did not want to talk. The SO arranged for extra credit to be added to Mr Jackson's in-cell telephone account so he could contact his family. She increased Mr Jackson's observations to two every hour.

61. The SO held an ACCT review on 13 September with a nurse. The SO noted that Mr Jackson had collected his morning medication and felt better. Mr Jackson said he had no current thoughts of suicide and self-harm and the SO reduced his observations to one conversation in the morning and afternoon.

62. On 16 September, Mr Jackson saw an SMS worker and said that he was still drinking hooch to help him sleep.

Events of 19 and 20 September

63. At approximately 10.40pm on 19 September, Mr Jackson's partner telephoned the prison control room and spoke to an officer.

64. The officer told the investigator that Mr Jackson's partner said that she had spoken to Mr Jackson who told her that this would be their last conversation. Mr Jackson's partner was concerned that he was going to harm himself. She immediately passed this information to a CM (who was the Night Orderly Officer in charge of the prison overnight). She also updated the control room log.

65. The CM told the investigator that he asked the night patrol officer to complete a welfare check on Mr Jackson and to observe him during the night. The CM did not record this in Mr Jackson's ACCT document or in his NOMIS (electronic prison record). He told the investigator that he did not ask the night patrol officer if he had completed the welfare check. He said that he expected the officer to complete the welfare check and to contact him if there were any issues or concerns.

66. The night patrol officer told the investigator that he had checked Mr Jackson at approximately 7.40pm that evening. He noted that Mr Jackson's observation panel was covered by something. Mr Jackson asked him to leave his observation panel open so there was light for his budgie. He also asked him to avoid shining his torch in in his face in the morning because it woke him up. Mr Jackson appeared in good spirits and the officer did not have any concerns. He said that when he left Mr Jackson's cell, his observation panel was uncovered. He did not record this in Mr Jackson's ACCT document.

67. Shortly after 10.40pm, the night patrol officer went to Mr Jackson's cell to carry out a welfare check as instructed by the CM. Mr Jackson's observation panel was covered. The officer said he could hear the television and believed he heard movement in Mr Jackson's cell. He could not remember if the cell light was on.

68. CCTV showed that the night patrol officer left Mr Jackson's cell shortly after and he did not return until 11.40pm. He found that Mr Jackson's cell was in darkness, there were no signs of movement and Mr Jackson's observation panel was still covered. He banged on Mr Jackson's cell door but could not gain a response. He went to the wing office and telephoned the CM, who immediately attended with another officer.

69. The CM opened Mr Jackson's cell and saw him ligatured at the cell window. At 11.47pm, the officer radioed an emergency code blue (indicating a prisoner is unconscious or has breathing difficulties). The control room staff immediately called an ambulance. The night patrol officer used his anti-ligature knife to remove the ligature from Mr Jackson's neck. The CM started CPR. A defibrillator was attached to Mr Jackson and did not detect a shockable rhythm.

70. A nurse arrived very shortly after and assisted with emergency lifesaving support. Paramedics arrived at 12.05am and took over Mr Jackson's care. At 12.19am, the paramedics confirmed that Mr Jackson had died.

Information received after Mr Jackson's death

71. A search of Mr Jackson's cell after his death found five 2 litre bottles of hooch and an illicit mobile phone.

72. Mr Jackson's in-cell telephone account showed that in the 72 hours before his death, he attempted to call his partner over 300 times without success.

73. The investigator spoke to three prisoners after Mr Jackson's death. They said that Mr Jackson regularly used an illicit mobile phone to speak to his partner. Mr Jackson was often distressed after their conversations, and they offered him support and advice. The prisoners told the investigator that Mr Jackson was worried his partner would end their relationship.

Contact with Mr Jackson's family

74. Due to COVID-19 restrictions, the police broke the news of Mr Jackson's death to his family at approximately 8.30am on 20 September. At 10.00am, a prison family liaison officer telephoned Mr Jackson's father and offered support.

75. The prison contributed towards the cost of his funeral in line with national policy.

Support for prisoners and staff

76. After Mr Jackson's death, a prison manager 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.

77. The prison posted notices informing other prisoners of Mr Jackson'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 Jackson's death.

Post-mortem report

78. The pathologist gave Mr Jackson's cause of death as hanging. The toxicology report detected mirtazapine (prescribed medication), naproxen (non-prescribed medication and amphetamine (non-prescribed medication) in Mr Jackson's body.

Findings

Assessment of Mr Jackson's risk of suicide and self-harm

79. Mr Jackson was 17 years of age when he was sent to prison for life. He was regularly managed under ACCT suicide and self-harm prevention procedures before he moved to Gartree. When he arrived at Gartree in May 2016, he was assessed as suitable for the therapeutic community but decided to return to a standard residential wing in September 2019, after completing 27 months of therapy. Mr Jackson initially found it difficult to settle on A wing and he regularly used illicit substances.

80. Mr Jackson found the restricted regime imposed in March 2020, during the COVID-19 pandemic, difficult due to length of time he spent locked in his cell. He resumed his relationship with his partner during this time. Mr Jackson had regular video calls with his family and partner. Although Mr Jackson told staff he relied on his partner for support, their relationship was often difficult which impacted on his mood and behaviour.

81. Prison Service Instruction (PSI) 64/2011 on safer custody, requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm, and take appropriate action Mr Jackson had several of these risks including previous self-harm and suicide attempts, poor mental health, substance misuse, recent contact with psychiatric services, hopelessness, impulsiveness and relationship instability.

82. We consider that the ACCT procedures provided good, personalised support to Mr Jackson. Staff held regular and supportive multi-disciplinary case reviews which appropriately assessed Mr Jackson's risk. They added actions to Mr Jackson's caremap which reflected his mental health and substance misuse needs.

Blocked observation panels

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

84. In March 2021, six months before Mr Jackson's death, the Governor issued a Notice to Staff setting out the actions they must take if they found a blocked observation panel. The notice has been issued around five times since the Governor took up the role in 2020 and was issued most recently in November 2022.

85. The notice states that if a panel has been blocked, staff should ask the prisoner to remove the obstruction and if the prisoner fails to comply, staff must take immediate action to check on the prisoner's welfare. The notice explains that the cell should be entered in a way that is consistent with local instructions for entering cells and that particular care must be taken during the night state. The notice states that at night, the duty manager must be informed immediately of any blocked observation panel.

86. The notice acknowledges that prisoners might obscure their observation panel to use the toilet or to undress, but they might also do so in order to use drugs or to use an illicit telephone. The notice states that staff must make clear to prisoners the need to keep their observation panel clear and that if a prisoner repeatedly covers his observation panel, he should be managed using the IEP scheme or adjudication process.

87. The notice also states that staff should not accept an oral response alone and staff should always be able to clearly observe prisoners in case they are unwell or there is an emergency situation. The notice stresses that "A clear observation panel can help to save lives".

88. When the night patrol officer checked Mr Jackson at 10.40pm, he found that his observation panel was obscured. He did not obtain an oral response from him. He returned to Mr Jackson's cell at 11.40pm and found that the observation panel was still obscured, the cell was in darkness, and he could not hear any noise.

89. The issue of blocked observation panels has come up in three other death investigations at Gartree, and in 2021 we made a recommendation to the Governor to remind staff of the correct procedures.

90. The issue of blocked observation panels is a persistent one at Gartree and there is historic evidence of systemic failure to address the problem. It is worthy of note that the resident population is predominantly made up of prisoners serving very long sentences and with the obvious challenges that presents in trying to ensure conformity with prison rules. It is also relevant that there are no privacy screens for residents using their toilets. That being said, the observation panels are there for a reason and they should remain unobstructed and staff finding them covered should comply with local policy to mitigate the risk. Systemic failure is exactly the area that the Ombudsman should be making recommendations in. In this case we have noted that the Governor is aware of the issue, has taken several actions to try and change the culture amongst residents and officers and is currently engaged with delivering a re-training program to all of his staff that includes a section on the reasons why complying with the observation panel policy is important. 65% of staff have completed this program and as it is an ongoing effort to solve the problem we will, on this occasion, not make a further recommendation.

91. The actions of the night patrol officer fell below the standard required and it is disappointing that he stated that he was unaware of the correct procedure. The correct procedure for obtaining a response from the prisoner during roll checks forms part of the syllabus of prison officer training and it is also in the workbooks and forms part of the final exam. The Governor has issued more than one Notice to Staff on the issue and on the balance of probabilities it seems unlikely the officer was unaware of his responsibilities. Under normal circumstances we would be making a recommendation that discipline procedures were initiated. However, we note that the officer no longer works for HMPPS.

Clinical care

92. The clinical reviewer concluded that, overall, the clinical care Mr Jackson received at Gartree was equivalent to what he could have expected to receive in the community. Mr Jackson was under the care of mental health, substance misuse

and primary care services. Staff reviewed him at Multi-Disciplinary Meetings and healthcare staff were routinely involved in ACCT case reviews. The GP did not allow Mr Jackson to have his medication in possession again after the first overdose on 23 June 2020.

93. Mr Jackson took an overdose of naproxen and other medication on 15 August 2021. At the time of his death, he had naproxen and amphetamine in his system, both of which were not prescribed to him. Mr Jackson was able to access these drugs during the COVID-19 lockdown and when severe restrictions had been put in place on prisoner and visitor movements.

94. In 2015, Mr Jackson was diagnosed with ADHD which impacted on his behaviour. He was not always compliant with taking his ADHD medication. He received support from the mental health team and substance misuse service, but it was not clear if he was able to understand the impact of not taking his medication and when he refused treatment after he took an overdose. The clinical reviewer said that Mr Jackson did not always make decisions that were in his best interests despite the best efforts of prison and healthcare staff to keep him safe.

95. When Mr Jackson took an overdose on 15 August, a nurse decided that based on the amount of tablets Mr Jackson claimed to have taken, he should be taken to hospital. A custodial manager decided that Mr Jackson should have a blood test and remain at the prison until the results were known. The clinical reviewer was concerned that the delay in taking Mr Jackson to hospital for further investigations was not in accordance with NICE guidelines which state that treatment for paracetamol ingestion is most effective if given within eight hours. She found that Mr Jackson was not taken to hospital until nine hours after his overdose.

96. The Head of Security told the investigator that it was not normal practice for prisoners who have taken an overdose to remain in the prison until their blood test results are known unless there are serious security concerns that need further consideration. Prison staff are available to escort prisoners to hospital if there is a clinical need. We note that a nurse assessed Mr Jackson as a low clinical need and the custodial manager agreed that he should be taken to hospital if his condition deteriorated.

97. The clinical reviewer has made a recommendation about support for prisoners with learning difficulties and taking prisoners to hospital if there is a clinical need, which we do not repeat in this report, but which the Head of Healthcare and Governor will need to address.

Good practice

98. When Mr Jackson's partner telephoned the prison on 9 September 2021, concerned that he was going to harm himself, a SO held an interim ACCT review and increased Mr Jackson's level of observations. She also arranged for extra credit to be added to Mr Jackson's in-cell telephone account so he could contact his family for support. We consider her actions to be good practice. We invite the Governor to share this report with her so that she is aware of the Ombudsman's comments about her good practice.

Governor to Note

Emergency response

99. At night, officers have a key in a sealed pouch for use in an emergency. PSI 24/2011, which covers management and security at nights, says that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment.

100. We do not criticise the night orderly officer for not entering Mr Jackson's cell immediately and alone when he was unable to get a response from him when he returned to his cell at 11.40pm. However, in these circumstances, staff should act with more urgency and use their radio to summon assistance, instead of the telephone. The Governor will wish to consider this.

INQUEST

101. At the inquest, which took place between 22 and 26 January 2024, the Coroner concluded that Mr Jackson died of misadventure.

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