

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Adam Thompson, a prisoner at HMP Northumberland, on 4 November 2022**

**A report by the Prisons and Probation Ombudsman**

Third Floor, 10 South Colonnade  
Canary Wharf, London E14 4PU

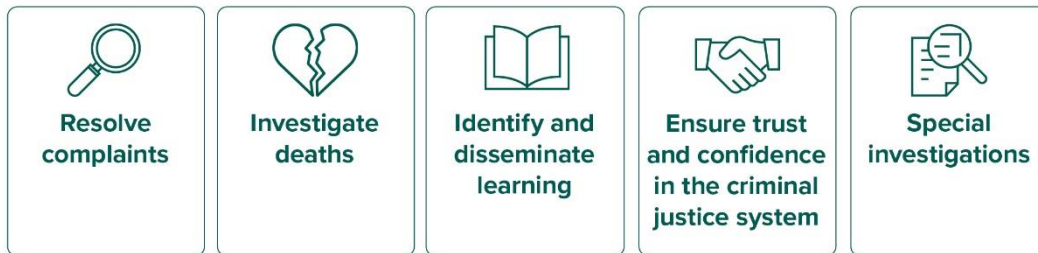
Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100

## 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



© Crown copyright, 2024

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](https://nationalarchives.gov.uk/doc/open-government-licence/version/3)

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Adam Thompson died on 4 November 2022, after he was found hanging in his cell at HMP Northumberland. He was 33 years old. I offer my condolences to Mr Thompson's family and friends.

Mr Thompson had been in prison for only three weeks, and at Northumberland for only two, when he died. Mr Thompson was highly anxious throughout his time in prison because he thought other prisoners were going to attack him. His mental health declined, and staff started suicide and self-harm procedures (known as ACCT) on 24 October. A psychiatrist assessed that Mr Thompson had psychosis caused by previous substance misuse and prescribed antipsychotic medication.

On 30 October, Mr Thompson made a deep cut to his wrist which needed hospital treatment. He returned to Northumberland the next day and refused to return to his cell as he said he was at risk. He was placed in the segregation unit instead and seemed more settled there. Staff stopped ACCT monitoring on 2 November. Mr Thompson was found hanging two days later.

I am concerned that staff stopped ACCT procedures prematurely on 2 November. This was only two days after Mr Thompson returned from hospital after cutting his wrist. I am also concerned that medication issues were unresolved when staff decided to stop ACCT monitoring. At a previous review, a mental health nurse had agreed to find out why Mr Thompson's medication dose was much lower than he was prescribed in the community. There is no evidence that she ever did this and at the final case review, she said that the medication dose had been increased when it had not. The clinical reviewer concluded that the mental health care Mr Thompson received at Northumberland was not equivalent to that which he could have expected to receive in the community.

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**

**August 2023**

# Contents

Summary .....	1
The Investigation Process.....	4
Background Information.....	5
Key Events.....	7
Findings .....	13

# Summary

## Events

1. On 7 October 2022, Mr Adam Thompson was sentenced to seven months and 26 days in prison for assault and breaching a suspended sentence. He was sent to HMP Northumberland on 14 October.
2. Mr Thompson had post-traumatic stress disorder (PTSD), a history of alcohol and substance misuse and a history of drug-induced psychosis. He was highly anxious throughout his time in prison because he thought that other prisoners were going to attack him.
3. On 24 October, staff started suicide and self-harm monitoring (known as ACCT) after Mr Thompson expressed thoughts of suicide. The next day, a psychiatrist assessed Mr Thompson and concluded that he had psychosis caused by previous substance misuse. He prescribed antipsychotic medication.
4. Mr Thompson made a deep cut to his wrist on 30 October, which required hospital treatment. When he returned to Northumberland on 31 October, he refused to go back to his cell as he said he was at risk there. He asked to go to the Care and Separation Unit (CSU – the segregation unit) and a senior manager agreed.
5. On 2 November, Mr Thompson said he felt much safer on the CSU and was no longer hearing people talking about him through the walls. Staff stopped ACCT monitoring.
6. On 4 November, during the duty manager rounds in the CSU, Mr Thompson whispered to the duty manager that he wanted a transfer to HMP Wetherby. The duty manager noted that Mr Thompson seemed very paranoid and had told him that he was at risk everywhere in the prison.
7. Mr Thompson telephoned his mother and brother that afternoon. He told them that other prisoners were going to attack him. He told his mother that he did not think he was going to make it out of prison.
8. Later that day, Mr Thompson asked an officer for a radio. Mr Thompson already had a radio in his cell, but this had not been recorded on the board outside his cell. The officer checked the board and also had a quick look in the cell and could not see a radio, so he gave one to Mr Thompson.
9. At 7.28pm, during a routine check, an officer found Mr Thompson sitting on the floor of his cell with the cords from both radios tied round his neck and attached to the sink taps.
10. Staff and paramedics tried to resuscitate Mr Thompson, but they were unsuccessful. At 8.15pm, paramedics pronounced that Mr Thompson had died.

## Findings

11. We are concerned that staff closed Mr Thompson's ACCT prematurely, only two days after he had returned from hospital after he had cut his wrist. We are also concerned that his medication issues remained unresolved when staff decided to close the ACCT. At the case review on 31 October, a mental health nurse had agreed to look into Mr Thompson's medication dose (which was much lower than he had been prescribed in the community), but she never did so. At the case review on 2 November, she said that Mr Thompson's medication had been increased but this was incorrect. We are concerned that this inaccurate information influenced the decision to close the ACCT.
12. We also found that aspects of the ACCT process were managed poorly, including that not all relevant people were involved in case reviews and some actions were not recorded on the care plan.
13. On 4 November, Mr Thompson showed signs that he had become more paranoid again, which staff should have recognised as an indication that Mr Thompson's risk of suicide and self-harm had increased. Staff should have considered reopening the ACCT in consultation with the mental health team, but there is no evidence that they did so.
14. The clinical reviewer found that Mr Thompson received appropriate care for his mental health up to 24 October but that after this, the care was inadequate due to the poor input to the ACCT case reviews. She concluded that the care Mr Thompson received at Northumberland for his mental health was not equivalent to that which he could have expected to receive in the community.
15. The officer made appropriate checks when Mr Thompson asked him for a radio. It is unfortunate that the board outside the cell had not been updated. Since Mr Thompson's death, CSU staff now list a prisoner's belongings on a board in the office, as well as outside the cells.

## Recommendations

- The Director and Head of Healthcare should ensure that staff manage prisoners being monitored using ACCT in line with prison policy, in particular that they:
  - invite all relevant staff involved in supporting the prisoner to case reviews;
  - discuss and record how identified sources of support should be involved in the ACCT process;
  - record care plan actions and ensure they are followed up;
  - refer cases to the Safety Intervention Meeting when prisoners are segregated; and
  - are alert to any changes in the prisoner's behaviour during the post-closure period that may indicate increased risk and consider whether the ACCT should be reopened.

- The Head of Healthcare should ensure that mental health staff attending ACCT reviews have relevant and accurate information about a prisoner, including their medication, and actively contribute to the review.

## The Investigation Process

16. The investigator issued notices to staff and prisoners at HMP Northumberland informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
17. The investigator obtained copies of relevant extracts from Mr Thompson's prison and medical records.
18. NHS England commissioned an independent clinical reviewer to review Mr Thompson's clinical care at the prison. The investigator and clinical reviewer jointly interviewed 11 members of staff.
19. We informed HM Coroner for Northumberland of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
20. The Ombudsman's family liaison officer contacted Mr Thompson's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She asked
  - How was Mr Thompson able to cut his wrists while on an ACCT?
  - Was Mr Thompson on an ACCT when he was found hanging on 4 November?
  - Why did he not have a television?
  - What assessment was made before giving Mr Thompson a radio?
  - Was Mr Thompson's medication appropriate?
  - Did the investigator have access to Mr Thompson's telephone calls?

We have addressed these issues in the report.

21. We shared our initial report with HM Prison and Probation Service (HMPPS). They identified some factual inaccuracies, which are amended in this report.
22. We provided Mr Thompson's next of kin with a copy of our initial report. They did not raise any issues or comment on the factual accuracy of the report.

## **Background Information**

### **HMP Northumberland**

23. HMP Northumberland, run by Sodexo Justice Services, is a category C prison which holds around 1,350 male prisoners. Spectrum Community Health CIC provides healthcare services. Healthcare staff are on duty from 7.30am to 7.30pm, Monday to Friday. Tees, Esk, and Wear Valley Mental Health NHS Foundation Trust are contracted to provide mental health services.

### **HM Inspectorate of Prisons**

24. The most recent inspection of HMP Northumberland was in August and September 2022. Inspectors found that safety and respect had improved at the prison since their last inspection in 2017. Inspectors were concerned that the number of self-inflicted deaths at Northumberland was higher than at most comparable prisons. Assessment, Care in Custody and Teamwork (ACCT) documents for prisoners at risk of suicide and self-harm were poorly completed and prisoners said they did not feel supported.
25. Inspectors said that the Care and Separation Unit was quiet, and staff knew prisoners well.

### **Independent Monitoring Board**

26. 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 31 December 2021, the IMB reported that prisoners were in a safe environment, and that many of the prison's initiatives supported prisoners to feel safe.
27. The prison introduced an action plan to ensure ACCTs were monitored weekly by safer custody staff. New ACCT documentation and procedures were introduced, and staff were given additional training. The IMB said they would continue to monitor the appropriate opening, completion and closure of ACCTs.

### **Previous deaths at HMP Northumberland**

28. Mr Thompson was the fourteenth prisoner to die at Northumberland since November 2020. Of the previous deaths, four were self-inflicted, one was drug-related and eight were from natural causes. In previous investigation, we have found that ACCTs were closed prematurely, and not reopened when there was concern about a prisoner's presentation.

### **Assessment, Care in Custody and Teamwork**

29. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

30. As part of the process, a care plan (plan of care, support and intervention) is put in place. The ACCT should not be closed until all the actions on the care plan have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison.

## Key Events

31. On 7 October 2022, Mr Adam Thompson was sentenced to seven months and 26 days imprisonment for assault and breaching a suspended sentence imposed in March 2021. He was sent to HMP Durham. He had been in prison before, in 2015.
32. Mr Thompson's Person Escort Record (PER – a form that accompanies prisoners between police custody, courts and prisons that sets out the risks they pose) included a suicide and self-harm warning form. It said that Mr Thompson would be at risk of suicide and self-harm if he returned to prison.
33. Mr Thompson told the reception nurse at Durham that he drank alcohol daily and used cocaine. He said he had post-traumatic stress disorder (PTSD) and drug induced psychosis and was prescribed depot injections (an antipsychotic long lasting injection) in the community, though had not had them recently as he had been evading police. Mr Thompson said he had tried to take his life six months earlier. He was sectioned and sent to a psychiatric hospital for two weeks. After that, he was under the care of the community mental health team. He said he had now reconciled with his family, was looking to the future, and said he had no thoughts of suicide or self-harm. The nurse referred Mr Thompson to the prison's mental health team and for alcohol withdrawal monitoring for the next three nights (he showed no withdrawal signs during that time).
34. Later that day, another nurse referred Mr Thompson to Substance Misuse Services (SMS) and alcohol intervention services.
35. On 12 October, a nurse saw Mr Thompson for a mental health triage. He said he felt anxious and paranoid because he had issues in the prison. He said that he had had fights with other prisoners in the past and was worried he would be attacked so he left his cell only for short periods. He asked for a transfer to HMP Northumberland. There was no evidence that Mr Thompson was being threatened.

## HMP Northumberland

36. Mr Thompson was moved to Northumberland on 14 October. The reception nurse referred him to the mental health team for assessment. Mr Thompson was located on Houseblock Three, the induction unit.
37. On 16 October, Mr Thompson told staff he wanted to isolate in his cell as he was under threat from prisoners.
38. On 19 October, Mr Thompson refused to leave his cell for a mental health assessment with a nurse. The nurse spoke to Mr Thompson by telephone. Mr Thompson said he was afraid to leave his cell as he thought he would be attacked. He refused to give any more detail. Mr Thompson agreed to an assessment later that afternoon.
39. Mr Thompson told the nurse that he had PTSD as a result of his service in the Royal Marines, and that he suffered night tremors. Mr Thompson said he would not leave his cell as he had been targeted by prisoners, though he could not give any specific details.

40. Mr Thompson asked the nurse if he could resume his depot injections. The nurse said he would check but thought he would probably be prescribed oral medication.
41. The nurse spoke to Mr Thompson's community psychiatric nurse on 21 October. The nurse said that Mr Thompson had been prescribed 20mg olanzapine (an antipsychotic), which he stopped taking, so was then prescribed paliperidone (also an antipsychotic) depot injections.
42. That day, Mr Thompson was moved to Houseblock Two, which houses vulnerable prisoners.
43. Mr Thompson's mother telephoned the prison on 23 October. She said she was concerned about her son. She said Mr Thompson had not had his medication and thought people were going to kill him. Healthcare staff were briefed about this call. Houseblock staff checked on Mr Thompson and referred him for a mental health assessment.
44. Mr Thompson's mother telephoned the prison again on 24 October. She said Mr Thompson had told her that prisoners were trying to get into his cell. She said that Mr Thompson seemed paranoid as he was not having his depot injections. An officer checked on Mr Thompson and assured him that his cell door was secure.
45. That day, Prison Custody Officer (PCO) A, who was Mr Thompson's key worker, contacted the nurse. He was concerned that Mr Thompson was refusing to leave his cell and his mental health appeared to have deteriorated.

## **ACCT – 24 October to 2 November**

46. The nurse met Mr Thompson that afternoon. Mr Thompson asked that PCO A was present. The nurse noted Mr Thompson looked slightly dishevelled and was still afraid to leave his cell. Mr Thompson appeared agitated, distressed, frightened and suspicious throughout their discussion. Mr Thompson was worried about his cell because it had an adjoining cell (a buddy cell) and he thought prisoners could use it to get into his cell. He was also suspicious his prison food had been tampered with. The nurse noted that Mr Thompson seemed psychotic. He planned for him to be seen by a psychiatrist the next day for an urgent review.
47. Mr Thompson told the nurse and PCO A he felt suicidal and had been having thoughts of self-harm but refused to go into more detail. The nurse and PCO A started suicide and self-harm monitoring (known as ACCT). The nurse noted that he planned for Mr Thompson to see a psychiatrist with a view to starting antipsychotic medication and referred him to a psychologist for support and stabilisation work.
48. That afternoon, staff moved Mr Thompson to a different cell on Houseblock Two.
49. At 5.00pm, a prison manager held the first ACCT case review. Mr Thompson and the ACCT assessor attended. The manager noted that no healthcare staff were available to attend, but they would hold a multidisciplinary ACCT review the next day. Mr Thompson seemed in better spirits as he had moved cells. He spoke about his time in the Royal Marines and the effect it had on him. It was agreed Mr Thompson would be signposted to SSAFA (Soldiers, Sailors, Airmen and Families Association) and other veteran agencies. The case review team reduced

observations from hourly to two in the morning, two in the afternoon, and five times during the night.

50. At 10.00am on 25 October, a Senior Prison Custody Officer (SPCO) held the second case review. PCO A and a mental health nurse attended. The SPCO noted that Mr Thompson was in good spirits, but he said he was not getting his depot injections. He noted that Mr Thompson was due to see a psychiatrist that afternoon who would prescribe antipsychotic medication. The case review team reduced observations to one during the morning and afternoon, and four times during the night.
51. A psychiatrist saw Mr Thompson that afternoon. Mr Thompson told him that other prisoners were out to get him, and he could hear them outside his cell talking about harming him. He said prisoners were trying to burn through his cell door with battery acid and he believed he had a price on his head. He said he had no thoughts of suicide or self-harm.
52. The psychiatrist assessed that Mr Thompson had psychosis caused by previous substance misuse. He prescribed 5mg olanzapine.
53. On 27 October, Mr Thompson told the SPCO that prisoners had cell keys and were going to come into his cell. Mr Thompson said he was not paranoid and that he had heard them talking about it. On 29 October, Mr Thompson told the SPCO that 50 prisoners were coming to get him and asked to move cells again. The SPCO tried to reassure Mr Thompson.
54. At around 9.15pm on 30 October, Mr Thompson rang his emergency cell bell. When an officer responded, Mr Thompson showed him that he had made a deep cut to his wrist. Mr Thompson was taken to hospital where his wound was stitched. He returned to Northumberland at around 4.30am on 31 October.
55. Mr Thompson refused to return to Houseblock Two and said he would only feel safe in the Care and Separation Unit (CSU – the segregation unit). He said prisoners were out to get him and that staff did not believe him. The duty manager gave authority for Mr Thompson to go to the CSU. The manager said it was the most suitable option during the prison's night state. Staff increased Mr Thompson's ACCT observations to five an hour until his next ACCT review. (This is the standard level of observations for prisoners moved to the CSU while on an ACCT until a case review can be held.)
56. That night, Mr Thompson's mother telephoned the prison and said that she was concerned that Mr Thompson might hurt staff. The night orderly officer was informed, and he briefed CSU staff.
57. On 1 November, Mr Thompson spoke to his mother on the telephone. He had been crying and said he would be dead by the next morning. He said prisoners were going to get him. Staff sent a report to the mental health team who responded that Mr Thompson had seen a psychiatrist, was working with their service and was on an ACCT.
58. That afternoon, a SPCO held the third case review. A PCO and a nurse attended. Mr Thompson said he had cut his wrist because he needed to move from the

houseblock. He said he could hear prisoners plotting to get him. The nurse agreed to look into Mr Thompson's medication as he had been prescribed 20mg olanzapine in the community but was now on 5mg. Mr Thompson said he wanted to move from Northumberland because prisoners thought he was a "grass". Mr Thompson said he had no thoughts of suicide and would not self-harm again. The case review team reduced observations to two in the morning, afternoon and evening, and five times during the night.

59. On 2 November, Mr Thompson attended a joint case review and Segregation Review Board. A CSU manager chaired the case review and two nurses, and a manager, attended. Mr Thompson said that he was in a better place since moving to the CSU. He was eating and sleeping well and was no longer hearing people talking about him through the walls. He said he had had no thoughts of suicide or self-harm since being in the CSU. He asked if he could remain in the CSU for his entire sentence, but staff told him that this would not be possible. He said he was engaging with the mental health team and his antipsychotic medication had been increased. The CSU manager noted that a nurse confirmed this and said that she could already see the change in his appearance and demeanour. (Mr Thompson's medication had not been increased as it remained at 5mg.) The case review team closed the ACCT.

## **2 to 3 November**

60. Mr Thompson telephoned his mother at 2.30pm. She said he sounded much better, and Mr Thompson said he was. He said he had a book and a radio and was showering and eating properly. He told his mother he had cut his wrist to get off the wing because he was being tortured, but nobody believed him. He said he was happy in the CSU.
61. On 3 November, the duty manager, who was doing his rounds in the CSU, noted that Mr Thompson had requested a transfer to another prison. It was noted in the ACCT post-closure monitoring form that Mr Thompson had a quiet day, accessed the CSU regime and no issues were reported.

## **Events of 4 November**

62. A duty manager carried out rounds in the CSU on 4 November. That morning he opened Mr Thompson's cell door. Mr Thompson immediately stepped forward and began whispering to him. Mr Thompson said he wanted a transfer to HMP Wetherby.
63. The duty manager saw Mr Thompson again that afternoon. Mr Thompson had been out of his cell using the telephone. He noted in Mr Thompson's prison record that he appeared very paranoid and on edge and had asked him to get him out of prison as he was at risk. He noted in the daily review summary, part of the CSU Daily Log, that Mr Thompson said he was at risk everywhere in the prison and had requested a transfer.
64. At 2.12pm, Mr Thompson telephoned his mother. He said prisoners were coming to get him that night and were going to burn him. He said he had asked for a transfer

to another prison. Mr Thompson ended the call by saying “I don’t think I’m going to make it out and I just wanted to hear your voice one last time. I absolutely love you.”

65. At 2.26pm, Mr Thompson telephoned one of his brothers. Mr Thompson said he had self-harmed to get off the wing, that he had been tortured and was being called a grass. He said prison staff were not listening. Mr Thompson told his brother he loved him. His brother replied that he loved him too, and not to do anything daft. Mr Thompson said he would not.
66. At approximately 5.05pm, PCO B responded to Mr Thompson’s cell bell. Mr Thompson asked for a radio, one of the authorised items prisoners are permitted to have in the CSU. PCO B told the investigator he had not heard music from Mr Thompson’s cell, and it was not marked on the plastic board outside the cell that he had been given a radio. He could not see a radio in Mr Thompson’s cell, so gave him one.
67. PCO C had been on duty in the CSU during the day of 4 November. He noticed nothing unusual about Mr Thompson. At approximately 7.15pm, PCO D went to the CSU to take over from PCO C. At 7.28pm, PCO D started a roll check (count of prisoners). He went to Mr Thompson’s cell first, because his cell light was on. He could not see Mr Thompson in the cell initially and thought he might be using the toilet. However, he continued to look and saw Mr Thompson sitting on the floor, next to the sink, with a ligature (two radio cords) around his neck, attached to the sink taps. He immediately radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). He waited outside the cell for other staff to arrive. He told the investigator that staff had been told not to go into Mr Thompson’s cell alone due to concerns that he might try to harm staff.
68. PCO D waited less than a minute before he heard another PCO approach. As soon as he heard her, he unlocked the cell door and they both went into the cell. He used his anti-ligature knife to cut the ligature, which had been made from the cord from the prison radio. They checked whether Mr Thompson was breathing or had a pulse. He did not. Both officers lowered Mr Thompson’s head onto the floor, and PCO D immediately started CPR.
69. Other staff responded to the code blue, including the night orderly officer and a SPCO, who took over chest compressions from PCO D. A PCO collected the defibrillator and applied it to Mr Thompson. The machine advised no shock and staff continued CPR.
70. Paramedics arrived at Mr Thompson’s cell at 7.50pm. They continued CPR until 8.15pm, when they pronounced that Mr Thompson had died.

## **Contact with Mr Thompson’s family**

71. The prison appointed two SPCOs as family liaison officers. They visited Mr Thompson’s mother to break the news of his death.
72. The prison contributed to the cost of Mr Thompson’s funeral, in line with national instructions.

## **Support for prisoners and staff**

73. After Mr Thompson's death, a SPCO 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.
74. The prison posted notices informing other prisoners of Mr Thompson'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 Thompson's death.

## **Post-mortem report**

75. The post-mortem report concluded that Mr Thompson died from pressure on the neck caused by hanging.

# Findings

## Assessment of risk of suicide or self-harm

76. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)* sets out the procedures (known as ACCT) that staff should follow when they identify that a prisoner is at risk of suicide and self-harm.
77. Staff supported Mr Thompson using ACCT from 24 October to 2 November. He died two days after staff stopped ACCT monitoring.
78. We are concerned that ACCT procedures were stopped prematurely, only two days after Mr Thompson returned from hospital after cutting his wrist. We are also concerned that Mr Thompson's medication issues remained unresolved when staff made the decision to close the ACCT. At the case review on 31 October, a nurse said she would look into Mr Thompson's medication dose (why he was on 5mg when he had been on 20mg in the community), but there is no evidence she did so. Nor is it recorded as an action in Mr Thompson's care plan. When the decision was made to close the ACCT on 2 November, the nurse said that Mr Thompson's medication dose had been increased, but this was not the case as he was still on 5mg. We are concerned that the nurse, who was representing the mental health team, gave inaccurate information, which may have influenced the decision to close the ACCT. The nurse no longer works at the prison, and we were unable to interview her.
79. PSI 64/2011 says that staff relevant to supporting the prisoner should be invited to case reviews. We would have expected Mr Thompson's key worker to have been invited to all the case reviews, but it appears that he was invited to only one of them, on 25 October. PSI 64/2011 also says that case reviews should be used to discuss and agree how identified sources of support can be used in the ACCT process. While staff identified that Mr Thompson's mother was a source of support, we saw no evidence that her role in the ACCT process was ever discussed.
80. The ACCT care plan was not always updated with relevant actions. During the ACCT review on 24 October, it was noted that Mr Thompson would be signposted to SSAFA and other veteran agencies for support. This was not noted in the care plan and there was nothing further about this in the ACCT paperwork. (The prison told us that Mr Thompson was referred.)
81. PSI 64/2011 says that all prisoners on an ACCT who are in segregation must be referred to the Safety Intervention Meeting (SIM - has responsibility for considering complex cases and providing support to ACCT case coordinators and case review teams). Staff did not refer Mr Thompson to the SIM when he was moved to the CSU.
82. On 4 November, a staff member noted that Mr Thompson appeared very paranoid and on edge and had asked to be moved because he was at risk everywhere in the prison. We consider that this was an indication that Mr Thompson's risk had increased, and we would have expected staff to consider reopening the ACCT. When asked about this at interview, the staff member said that Mr Thompson did

not appear to be in crisis and so he considered an ACCT was not needed. However, we consider that as Mr Thompson was presenting as 'very paranoid', there should have been an urgent reassessment of his risk and that the mental health team should have been contacted to feed into this assessment. We recommend:

**The Director and Head of Healthcare should ensure that staff manage prisoners being monitored using ACCT in line with prison policy, in particular that they:**

- **invite all relevant staff involved in supporting the prisoner to case reviews;**
- **discuss and record how identified sources of support should be involved in the ACCT process;**
- **record care plan actions and ensure they are followed up;**
- **refer cases to the Safety Intervention Meeting when prisoners are segregated; and**
- **are alert to any changes in the prisoner's behaviour during the post-closure period that may indicate increased risk and consider whether the ACCT should be reopened.**

**The Head of Healthcare should ensure that mental health staff attending ACCT reviews have relevant and accurate information about a prisoner, including their medication, and actively contribute to the review.**

## **Clinical care**

### **Mental health**

83. The clinical reviewer concluded that Mr Thompson's mental health care was not equivalent to that which he could have expected to receive in the community.
84. The clinical reviewer acknowledged that up to 24 October, Mr Thompson received responsive and appropriate care for his mental health. However, she found that Mr Thompson's mental health management after this was inadequate. This was due to the poor input into the ACCT case reviews by a nurse, as discussed above.

### **Radios**

85. In the CSU, there are boards outside each cell that should list the items a prisoner has in their cell, what date it was given to them and by whom. On 4 November, Mr Thompson asked PCO B for a radio, even though he already had one in his cell. PCO B said he had not heard music from Mr Thompson's cell, it was not listed on the board outside the cell, and he could not see a radio when he looked into the cell.
86. We are satisfied that PCO B checked whether Mr Thompson already had a radio before he gave him another. It is unfortunate that another officer had not updated

the board outside the cell. Since Mr Thompson's death, CSU staff now list a prisoner's belongings on a board in the office, as well as outside the cells.

87. We note the change to property recording that has taken place since this incident occurred. If this proves to be workable good practice, then it should be disseminated to institutions with similar systems.

## **Inquest**

88. The inquest, heard on 2 February 2024, concluded that Mr Thompson died by suicide.

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

Third Floor, 10 South Colonnade  
Canary Wharf, London E14 4PU

Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100