Prisons &
Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Dealey, a prisoner at HMP Swaleside, on 1 August 2021

A report by the Prisons and Probation Ombudsman

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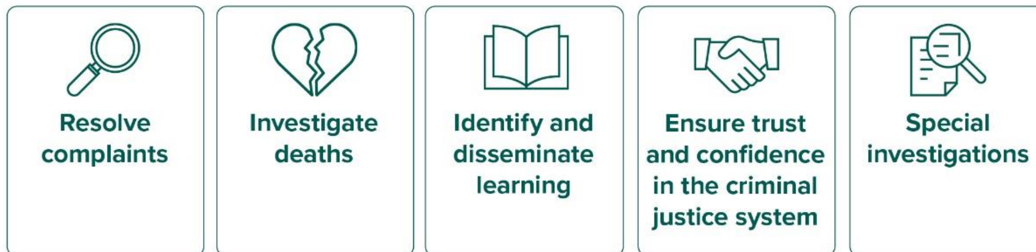
OUR VISION

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

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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

Mr Paul Dealey died after he was found hanged in his cell at HMP Swaleside on 1 August 2021, five days before he was due to be released. He was 40 years old. I offer my condolences to his family and friends.

I found evidence of effective risk management and support by staff, including appropriate referrals to the mental health team, the flexible use of the inpatient unit when Mr Dealey felt unsafe and efforts to transfer him to a prison closer to his home area. However, the decision to end suicide and self-harm monitoring was premature and no post-closure monitoring took place.

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 **November 2023**

Contents

Summary 1

The Investigation Process...4

Background Information...4

Key Events...7

Findings 14

Summary

Events

1. On 14 August 2019, Mr Dealey was recalled to prison, five days after he was released on licence. He was transferred to HMP Swaleside on 16 September 2020. Mr Dealey had a history of substance misuse and mental ill-health, including anxiety and depression.

2. In May 2021, officers referred Mr Dealey to the mental health team because he was not coming out of his cell very often or engaging with staff. The mental health team monitored and assessed Mr Dealey's mental health during the month of June.

3. On 5 July, a GP at Swaleside prescribed Mr Dealey anti-anxiety and antidepressant medications. The GP did not find any evidence of severe depression or anxiety but recorded that Mr Dealey would need support from the community mental health team after his release, which was due on 6 August.

4. On 26 July, an officer referred Mr Dealey to the mental health team again after becoming increasingly concerned about his paranoid behaviour. The next day, a mental health nurse reviewed the referral and discussed it with the mental health team. The team concluded that Mr Dealey's paranoia and anxiety levels had increased and that his care planning should be reviewed.

5. On the morning of 28 July, Mr Dealey smashed his cell door observation panel and barricaded his cell door using broken furniture. He also made cuts to his arms. Staff put additional monitoring in place under suicide and self-harm prevention procedures (known as ACCT), to manage the risks. They noted that Mr Dealey's mental health had rapidly deteriorated, and that he was feeling very paranoid and anxious about his upcoming release.

6. At around 12.30pm on 29 July, an ACCT review / Multi-Disciplinary Team (MDT) meeting took place to discuss Mr Dealey's mental health. The review decided that Mr Dealey should be moved to the inpatient unit in the prison's healthcare department as soon as possible, to help him feel safer. The move took place at 1.00pm.

7. At 10.45am on 30 July, Mr Dealey's next review meeting took place and staff agreed that his ACCT should be closed because his engagement, behaviour and presentation had improved, and he did not pose a risk to himself.

8. During the night of 31 July to 1 August, the Healthcare Assistant (HCA) on the inpatient unit completed hourly checks on Mr Dealey and raised no concerns. However, at around 6.30am, the HCA became concerned that Mr Dealey had been in the same position for several hours. The HCA spoke to his supervisor, who attended the cell and radioed a medical emergency 'code blue' (indicating a life-threatening situation) at 6.44am. Officers and healthcare staff responded to the code blue and found that Mr Dealey had a ligature around his neck. They cut the ligature and began cardiopulmonary resuscitation (CPR) but were unable to revive him. At 7.29am, paramedics confirmed that Mr Dealey had died.

Findings

Clinical care

9. The clinical reviewer concluded that overall, the clinical care provided to Mr Dealey was equivalent to that which he could have expected to receive in the community. However, she found issues with clinical assessment and discharge planning that the Head of Healthcare will need to address.

Management of risk of suicide and self-harm

10. We consider that the decision to close Mr Dealey's ACCT on 30 July was premature. There was limited evidence that his risk of suicide and self-harm had reduced and that he could be safety managed without additional monitoring. The post-closure ACCT monitoring process would have enabled a review of the decision, but this was not used by staff. The routine observations in place on the inpatient unit should not have been relied upon as an alternative method of monitoring Mr Dealey's welfare.

11. Staff did not follow the self-isolation policy when Mr Dealey withdrew from the regime.

12. We also consider that Mr Dealey's cell on the inpatient unit was not appropriate in the circumstances. Staff could not easily check him because of the unusual flap system on the door.

Emergency response

13. Staff delayed calling the medical emergency 'code blue' and entering the cell when Mr Dealey was discovered unresponsive. This does not appear to have impacted on the outcome for Mr Dealey, but a delay might have critical consequences in future emergencies.

Preparation for release from prison

14. Mr Dealey had no accommodation to move into on release. We note the steps taken by his Offender Supervisor (OS) to secure housing and recognise the national shortages that impact on this. The OS told us that accommodation support was limited at Swaleside because it was not a resettlement prison and because Mr Dealey's release area was far away from the prison.

Substance misuse

15. Mr Dealey had a long and documented history of substance misuse, and evidence suggests that he may have been in debt with other prisoners around the time he died. We are concerned that he was not referred to the substance misuse team until 11 July 2021, around 10 months after he arrived and shortly before his release. We consider that this was a serious oversight during the initial screening process.

Meaningful contact

16. We identified a lack of meaningful contact with staff in the months before Mr Dealey's death, due to staffing shortages during the COVID-19 pandemic.

Recommendations

- The Head of Healthcare should develop and issue guidance to healthcare staff which clarifies the process for inpatient unit referrals, to ensure that admissions are clinically appropriate, and that clinical support is in place.
- The Head of Healthcare should ensure that individual care plans are created and implemented for prisoners on the inpatient unit, to enable effective management of health conditions and to prepare them for release (if applicable)
- The Governor and Head of Healthcare should ensure that ACCT reviews thoroughly assess the risk presented by individuals and only approve closure where there is robust evidence that risks have reduced.
- The Governor and Head of Healthcare should remind all disciplinary and healthcare staff of the difference between standard inpatient healthcare observations and ACCT monitoring procedures, to ensure they are not viewed as alternatives.
- The Governor and Head of Healthcare should remind disciplinary and healthcare staff to complete the ACCT post-closure section, to ensure that any ongoing risks are appropriately monitored, and the ACCT is reopened where needed.
- The Governor and Head of Healthcare should review the suitability of cell 5 in the inpatient unit for prisoners who are vulnerable.
- The Head of healthcare should issue guidance to staff on the inpatient unit that clearly explains the purpose of and expectations for hourly observations.
- The Governor and Head of Healthcare should ensure that prisoners with a history of substance misuse are referred to the substance misuse team on arrival, to enable them to access the appropriate support.

The Investigation Process

17. 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. One prisoner responded and agreed to be interviewed.

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

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

20. The investigator, accompanied by the clinical reviewer, interviewed 13 members of staff and one prisoner at Swaleside. The interviews were completed by video link and telephone due to the restrictions imposed as a result of the COVID-19 pandemic.

21. We informed HM Coroner for Kent and Medway of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

22. The Ombudsman's family liaison officer contacted Mr Dealey's father, to explain the investigation and to ask if he had any matters, he wanted the investigation to consider. Mr Dealey's father did not have any questions, but said he thought his son may have taken "Spice" (also known as psychoactive substances or PS) around the time of his death. He said he did not know why his son would have taken his own life, when he had only five days until his release.

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

24. Mr Dealey's family received a copy of the draft report. They did not make any comments.

Background Information

HMP Swaleside

25. HMP Swaleside, on the Isle of Sheppey, is part of the Long-Term and High Security estate. It houses up to 1,112 men serving sentences of four years or more. Integrated Care 24 Ltd provides primary healthcare. There is 24-hour nursing cover and a 17-bed inpatient unit. GPs work in the prison Monday to Friday, and Medway on Call Care provides an out of hours GP service. Oxleas NHS Foundation Trust provides mental health services. The Forward Trust provides substance misuse treatment.

HM Inspectorate of Prisons

26. The most recent published inspection of HMP Swaleside was in July 2022. Inspectors reported that the shortage of officers was worse than at their previous inspection in October 2021, leading to very limited time out of cells for most prisoners. Good progress had been made in addressing inspectors' concerns about early days support and it was evident that a significant amount of effort had been put into creating a well-thought-out service. However, inspectors reported that staffing levels were now at 'crisis point' and this was having an impact on all aspects of the regime.

27. Inspectors reported that the rate of self-harm had declined considerably, but there had been five self-inflicted deaths: four since the last inspection and a fifth two months after their visit.

Independent Monitoring Board

28. 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 annual report, for the year to April 2021, the IMB found the prison had had a difficult year coping with the COVID-19 pandemic – at one point 150 staff were off work. Although they felt as a whole the prison had still managed to forge ahead and make some improvements regarding physical repairs and collaborative working, they remarked on the lack of meaningful activity or work available for prisoners which had been necessary to keep staff and prisoners safe.

29. In its most recent annual report, for the year to April 2022, the IMB found that the lack of key working, meaningful employment and activities was still a concern. They stated that it increased the frustration felt by prisoners, which in turn increased the levels of violence and self-harm. However, they noted that the provision of in-cell education packs helped alleviate boredom for those prisoners who were interested. The IMB stated that current staffing levels were very low. As a result, the support available for prisoners was inadequate and, seemingly, reducing year on year, which did not bode well for the future security of the establishment nor the provision of adequate support for prisoners.

Previous deaths at HMP Swaleside

30. Mr Dealey was the 12th prisoner at Swaleside to die since August 2019. Eight of the previous deaths were from natural causes, two were drug-related and one was self-inflicted. We found some similarities in our investigation findings following Mr Dealey's death and the previous self-inflicted death in 2021. Staff did not call a code blue straight away when they identified the emergency, and the substance misuse team did not share information about the prisoner's drug use with healthcare.

31. Since Mr Dealey's death, there have been seven further self-inflicted deaths. As a result, Swaleside is receiving support and monitoring from His Majesty's Prison and Probation Service Headquarters.

Assessment, Care in Custody and Teamwork (ACCT)

32. 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.

33. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, Management of prisons at risk of harm to self, to others and from others (Safer Custody).

Key worker scheme

34. The key worker scheme aims to improve safer custody by engaging with prisoners, building better relationships between staff and prisoners and helping prisoners settle into life in prison. It provides that all adult male prisoners will be allocated a key worker who will spend an average of 45 minutes a week on key worker activities, including having meaningful conversations which each of their allocated prisoners.

35. The key worker scheme was suspended across the estate on 24 March 2020 due to the COVID-19 pandemic. To ensure that meaningful interaction continued for priority prisoners, the Prison Service used an Exceptional Delivery Model until May 2022. This involved weekly conversations with prisoners identified as vulnerable.

Key Events

Background

32. Mr Paul Dealey had spent several periods in prison for a range of offences including theft and public disorder. He had a long history of class A substance misuse in the community and was found under the influence of psychoactive substances (PS) on several occasions in prison. He also had a history of mental ill-health, including anxiety and depression for which he had been prescribed medication, but this was withdrawn after he was found to be tampering with it. In 2016, doctors diagnosed Mr Dealey with attention deficit hyperactivity disorder (ADHD) and prescribed medication for the symptoms. Healthcare professionals also suspected that he had a personality disorder, however a formal diagnosis was never reached.

33. On 17 October 2018 at HMP Manchester, Mr Dealey threatened to take his life if staff did not move him onto a different wing. Staff monitored Mr Dealey under suicide and self-harm procedures known as ACCT, until 18 December 2018. Mr Dealey told them he was in debt and wanted to move wings for his own safety. Staff closed the ACCT once they were satisfied that the risk of suicide and self-harm had reduced and could be managed without additional monitoring.

36. Mr Dealey was released and recalled to prison several times. As result of this and his behaviours, he spent time in a variety of prisons. During a period at HMP Manchester, from 11 July to 25 August 2020, Mr Dealey refused his food. Staff monitored him under the ACCT process again. This was not the first time that Mr Dealey had refused food in prison.

37. In his final months at Manchester, Mr Dealey resided on the segregation unit after saying he wanted to self-isolate and exhibited disruptive behaviour. Mr Dealey's final transfer, from Manchester to HMP Swaleside, took place on 16 September 2020.

HMP Swaleside

38. At his initial health screening on 16 September, Mr Dealey said that he had a history of substance misuse and self-harm. He said he had not self-harmed for 12 months, but said he had a long history of ADHD, anxiety, depression and insomnia for which he had previously been prescribed medication until it was stopped. The nurse noted that Mr Dealey was waiting to see a doctor to review his medication. She referred him to the mental health team.

39. The next day, Mr Dealey was assessed by mental health nurse, in consultation with two other members of healthcare staff. The team concluded that Mr Dealey should be seen routinely for mental health assessments but did not think he needed any urgent or specific support or treatment at the time.

40. On 21 September, Mr Dealey told a nurse that he had not eaten for six days. He was speaking rapidly, appeared anxious and talked about his ADHD diagnosis. The nurse referred him to the GP and for counselling.

41. On 22 September, the mental health team discussed Mr Dealey's care at their team meeting. They reviewed his previous medication and identified behavioural

changes when he felt his needs were not being met. They also noted that Mr Dealey was requesting sealed meals because he thought his food was being tampered with. In interview, Mr Dealey's keyworker told us that Mr Dealey spent most of his time in his cell and self-isolated during his time at Swaleside. He also told us that although Mr Dealey told staff that he was on hunger strike, he was in fact eating. Officers concluded that there was no benefit in logging the food refusal. The mental health team agreed that no immediate action was required but that they would continue to monitor Mr Dealey.

42. On 2 October, the mental health team completed one of their regular assessments of Mr Dealey. They booked an appointment with the consultant psychiatrist at Swaleside for a review of Mr Healey's medication. Mr Dealey did not attend GP appointments on 2 October and 23 October for unknown reasons, however the mental health team continued to complete regular welfare checks. On 20 November, Mr Dealey decided not to attend a further GP appointment.

43. On 16 December, the consultant psychiatrist tried to complete a psychiatric appointment with Mr Dealey in his cell, over the telephone (this was due to COVID-19 restrictions). Mr Dealey did not answer the telephone. In interview, the psychiatrist told us that the average time it took for him to see a patient during the pandemic had increased from around three weeks to around two to three months. He said this caused stress for him, patients and the wider service.

44. On 6 January 2021, Mr Dealey spoke to the consultant psychiatrist on his in-cell telephone. The psychiatrist told us that he was confident that Mr Dealey had ADHD, because he observed symptoms including hyperactivity and impulsiveness. He was aware that Mr Dealey had not received any medication since July 2020 and could see that he was struggling without it. He prescribed medications to help with Mr Dealey's sleeping issues and ADHD. He arranged to review Mr Dealey in four to six weeks' time.

45. On 6 April, Mr Dealey met the consultant psychiatrist in person for the first time. Officers that knew Mr Dealey told the psychiatrist that Mr Dealey's behaviour had improved. They said he had been leaving his cell and interacting with other prisoners, which was unusual for him as he often self-isolated. At the meeting, Mr Dealey told the psychiatrist that he continued to have trouble sleeping and felt anxious and low in mood. The psychiatrist concluded that Mr Dealey had a panic disorder and prescribed an anti-anxiety medication for five days. They discussed psychological therapies and relaxation techniques.

46. On 12 May, wing staff referred Mr Dealey to the mental health team because he was not coming out of his cell very often or engaging with staff. On 28 May, the consultant psychiatrist met with Mr Dealey again and noted that he was due to be released from prison in around ten weeks' time. Mr Dealey told him that he became hyperactive if he was not engaged in purposeful activity and still had trouble sleeping. The psychiatrist prescribed more medication for insomnia and increased Mr Dealey's ADHD medication.

47. The mental health team continued to monitor and assess Mr Dealey during June.

July 2021

48. On 5 July, the consultant psychiatrist assessed Mr Dealey at a face-to-face meeting. He did not consider that Mr Dealey presented any evidence of severe depression or anxiety that he could not cope with. He recorded the need for a mental health review following release.

49. On 11 July, Mr Dealey's Offender Supervisor met Mr Dealey and recorded that he would have nowhere to live after his release from prison on 6 August. As a result, she referred him to the Leicester Housing Authority, which is where Mr Dealey intended to live upon his release.

50. On 20 July, Mr Dealey met his keyworker and another officer on the wing. They asked him why he was self-isolating and found that this may have been due to an outstanding debt, although Mr Dealey did not tell them this explicitly. Mr Dealey told them that he wanted to self-isolate until his release.

51. On 26 July, a Supervising Officer (SO) on G Wing referred Mr Dealey to the mental health team after becoming increasingly concerned about his behaviour and presentation.

52. On 27 July, a mental health nurse reviewed the SO's referral alongside Mr Dealey's healthcare notes and discussed it with the wider team. They concluded that Mr Dealey's paranoia and anxiety levels had increased and that he should be reviewed.

53. At around 9.30am on 28 July, a Custodial Manager (CM) completed a welfare check on Mr Dealey and found him in a paranoid, distressed state. He recorded that Mr Dealey had damaged his cell and was anxious about his impending release from prison. He also noted that Mr Dealey had made superficial cuts to his left forearm, had clad himself in makeshift armour and was threatening to escalate his behaviour by either self-harming or seriously assaulting staff or prisoners. The CM immediately contacted the mental health team and opened an ACCT. Staff put hourly observations in place to monitor Mr Dealey's wellbeing and included a requirement for one quality conversation in the morning and one in the afternoon.

54. At 10.00am, the mental health team tried to assess Mr Dealey but were unable to due to his distressed state. At 11.50am, a mental health nurse attended his wing and, with support from the CM, completed the mental health assessment. The nurse did not record any observations about Mr Dealey's physical or mental state but noted that an ACCT/MDT meeting was due to take place at 2.00pm that day.

55. The CM told the Offender Supervisor nurse about the deterioration in his mental health and anxiety surrounding release. The Offender Supervisor confirmed that because Mr Dealey was on a recall and about to reach the end of his sentence, he would not be subject to a licence or under probation supervision when released. Leicester Housing Authority told her that if Mr Dealey was released with nowhere to live (which appeared likely), he would have to contact them on the day he became homeless in order for them to try and find him a bed space. At the time, they had nowhere to house him. The Housing Authority could not give her any further help or assurances regarding Mr Dealey's housing situation. Mr Dealey was told this at the later ACCT review.

56. At around 2.30pm, Mr Dealey attended an ACCT review. Staff from healthcare, psychology, safer custody, the offender management unit (OMU) and officers on Mr Dealey's wing also attended.

57. A SO and the ACCT case coordinator recorded that Mr Dealey said he was in debt, concerned about his upcoming release from prison and struggling with his mental health. Mr Dealey told staff that he did not feel suicidal and did not want to harm himself. He repeatedly requested a move to the Care and Separation Unit (CSU), also known as segregation, which he felt it was the only place that was safe for him. The group decided to keep the ACCT open with two conversations a day (one in the morning and one in the afternoon) and two observations during the night.

58. On 29 July in the morning, a SO made another referral to the mental health team based on serious ongoing concerns about Mr Dealey's emotional welfare. Mr Dealey was already being monitored by the ACCT process, but the SO assessed that he might need additional support.

59. The mental health in-reach team meeting discussed the referral later that day. The team noted that Mr Dealey did not have a severe or enduring mental health diagnosis. They assessed that there was no specific input needed from the mental health team and that the referral was in effect a duplicate of that which had been dealt with the previous day. They agreed the SO should be signposted to other services including the Forward Trust, Chaplaincy, Offender Management and Primary Care which might be able to support Mr Dealey.

60. At around 12.30pm, staff held another ACCT review / MDT meeting due to continued concerns about Mr Dealey's emotional welfare. The review decided that Mr Dealey should be moved to the inpatient unit in the prison's healthcare department as soon as possible, rather than the CSU which they felt was unsuitable for him. They also considered that transferring Mr Dealey to a prison in the Leicester area would help him, so that he could reach support services and probation more easily when released. The group decided to keep his ACCT observations at the same level.

Move to the Inpatients Unit

61. At around 1.00pm on 29 July, officers escorted Mr Dealey to the inpatient unit and conducted a full search on arrival. They found two improvised bladed weapons, which were placed in evidence bags. Healthcare staff on the inpatient unit began completing hourly observations (basic, routine visual checks) on Mr Dealey, in line with standard procedures.

62. On 30 July at 9.10am, a nurse recorded in Mr Dealey's ACCT document that after damaging his cell overnight, he had been moved within the inpatient unit from cell 14 to cell 5 and placed on report for his actions. At 10.45am, a CM chaired an ACCT review for Mr Dealey on the inpatient unit. Mr Dealey attended the meeting alongside a nurse, his Offender Supervisor, a member of the substance misuse team, a member of psychology and the Head of Residence, who was ACCT co-chair. Mr Dealey spoke about his adverse childhood experiences, which he had not talked about before. He presented as paranoid about his safety in prison and on release. However, as the review progressed, he became more engaged, and his anxiety appeared to reduce. He said he wanted to start afresh upon his release and live in the countryside. Mr Dealey said he felt safer on the inpatient unit than

on a normal wing, and despite the stress of his release he said he would not self-harm or consider suicide as he loved himself too much. Staff noted that he was eating well.

63. The review agreed that Mr Dealey's ACCT should be closed, because Mr Dealey did not pose a risk to himself. The care plan was not updated, and a post closure review was scheduled for 5 August. Mr Dealey said he would ask for the CM if he needed further support. At interview, the CM told us that the hourly healthcare observations in place in the inpatient unit were a factor in the decision to close Mr Dealey's ACCT.

64. The Head of Residence submitted an urgent transfer request to HMP Lowdham Grange for Mr Dealey, which was near his hometown of Leicester and would help with his transition into the community following release. However, Lowdham Grange were unable to accept him as they did not have space. We understand that staff then put in a transfer request to HMP Leicester, but this was also unsuccessful.

65. Between 9.00am and 9.00pm on 31 July, a healthcare assistant on the inpatient unit completed basic visual checks on Mr Dealey and raised no concerns.

66. From 9.00pm, a healthcare assistant (HCA) completed hourly observations on Mr Dealey. At interview, he told us that observation times were staggered so that prisoners did not know exactly when the check would take place. He was supervised by the emergency response nurse. However, the nurse was not involved in the checking process. The HCA told us that it was difficult to conduct the visual checks on Mr Dealey because of a vertical flap system in the cell door that obscured the view.

67. At around 11.00pm, the HCA recorded on the observation chart that Mr Dealey was awake and talking to staff.

1 August

68. At midnight, the HCA noted that Mr Dealey was engaging with staff members. At 3.00am, he saw Mr Dealey pulling out the cupboards in his cell.

69. At around 4.00am, the HCA noted that Mr Dealey, "appeared to be dozing off" on the cell floor. At interview, he told us that he could see the lower part of Mr Dealey's legs but could not see his body because he was at an angle behind the door.

70. At around 5.00am, the HCA recorded that Mr Dealey was, "sitting on the floor and appeared asleep". As before, he could not see Mr Dealey's upper body.

71. At some time between 6.05 and 6.40am (we are unable to corroborate the exact timing as there was no CCTV in the area and the HCA said that he did not record the exact times of his checks), the HCA checked Mr Dealey and saw that he was in the same position. At interview, he said he became concerned at this point and tried to speak to Mr Dealey but received no response. At around 6.30 – 6.40am, he went to speak to the emergency response nurse, who was a few seconds away in his office.

72. The HCA and emergency response nurse attended the cell and started banging on the door and calling Mr Dealey's name. At 6.44am, when they did not receive a response, the nurse radioed a medical emergency 'code blue', indicating a life-threatening situation. At interview, the nurse told us that healthcare staff did not have keys to the cells on the inpatient unit, so could not enter until officers arrived to unlock them.

Emergency response

73. A CM and officers responded quickly to the code blue call. They arrived at Mr Dealey's cell at 6.46am.

74. The CM tried to open the cell door but struggled because Mr Dealey's body was blocking it. He managed to squeeze into the cell and saw that Mr Dealey had a ligature around his neck. An officer went into the cell and cut the ligature from around Mr Dealey's neck.

75. In his statement following Mr Dealey's death, the CM noted that Mr Dealey showed clear signs that he had been dead for some time. An officer began performing cardiopulmonary resuscitation (CPR), with support from the emergency response nurse and the HCA. Staff attached a defibrillator (a device that can give a high energy shock to someone who is in cardiac arrest), and no shock was advised. Staff continued with chest compressions until the ambulance crew arrived shortly after 7.00am. At 7.29am, paramedics confirmed that Mr Dealey had died.

Contact with Mr Dealey's Family

76. The prison's family liaison officer (FLO) tried to contact Mr Dealey's father on 1 August. The prison did not have a telephone number for Mr Dealey's father and searched Mr Dealey's prison records for possible contact details. When they could not find a correct telephone number, the FLO asked Leicestershire Police for help.

77. Leicestershire Police confirmed that Mr Dealey's father still lived at the same address, however the three further telephone numbers they supplied failed to connect. The Coroner's Office sent out a letter and an interim death certificate, which Mr Dealey's father received. Mr Dealey's ex-partner contacted the prison and gave the FLO the correct contact details for Mr Dealey's father. The FLO was able to make contact and let Mr Dealey's father know about his death.

78. Swaleside contributed to the costs of Mr Dealey's funeral, in line with Prison Service instructions.

Support for prisoners and staff

79. A senior manager held a debrief with prison staff involved in the emergency response. All staff were offered the support of the prison's care team.

80. The senior manager posted notices informing other prisoners of Mr Dealey's death and offering support in case they had been adversely affected.

Post-mortem report

81. The post-mortem report concluded that the cause of Mr Dealey's death was hanging.

82. Toxicology tests found that amphetamine was present in Mr Dealey's system, however this was at a therapeutic level and did not contribute to his death. The presence of amphetamine may be accounted for by the prescription of lisdexamfetamine (for treatment of ADHD) which Mr Dealey was receiving.

Findings

83. Mr Dealey presented with complex issues including mental health concerns, challenging behaviour, anxiety about his upcoming release and a history of self-harm. He had been at Swaleside for ten months when he died. The investigation found that both prison and mental health staff worked hard to understand and support Mr Dealey. They were alerted to changes in his presentation, particularly when he became increasingly paranoid or introverted and there was evidence of swift referrals and personalised care and consideration.

Clinical care

84. The clinical reviewer concluded that overall, the clinical care provided to Mr Dealey at Swaleside was equivalent to that which he could have expected to receive in the community. However, she commented that Mr Dealey's regular prison transfers and long periods of seclusion meant that it was virtually impossible for staff to provide good continuity of care between prisons. There are a range of factors that result in prison transfers and that some of these cannot be avoided, however Mr Dealey had complex needs that would have benefitted from more consistent care.

85. The clinical reviewer also found some specific areas of learning on the clinical care provided to Mr Dealey at Swaleside.

86. Mr Dealey's move to the inpatient unit was driven by the need to find somewhere secure and appropriate for him to reside prior to his imminent release. However, the clinical reviewer found that there was no clear care plan for Mr Dealey during his time in the inpatient unit, with no clinical assessment or discharge planning to ensure that he would be connected to local clinical services following release. We make the following recommendations:

- **The Head of Healthcare should develop and issue guidance to healthcare staff which clarifies the process for inpatient unit referrals, to ensure that admissions are clinically appropriate, and that clinical support is in place.**
- **The Head of Healthcare should ensure that individual care plans are created and implemented for prisoners on the inpatient unit, to enable effective management of health conditions and to prepare them for release (if applicable).**

Management of risk of suicide and self-harm

87. Prison Service Instruction (PSI) 64/2011 Safer Custody contains national requirements on ACCT suicide and self-harm prevention procedures. It requires that all staff who have contact with prisoners are aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action.

88. We have considered whether staff acted appropriately when they closed Mr Dealey's ACCT on 30 July, two days before his death. Decisions on whether to close an ACCT are finely balanced, and we understand the challenges staff

encounter in assessing risks, particularly those presented by individuals with complex needs and behaviours.

89. At interview, staff told us that during Mr Dealey's final ACCT review on 30 July, he said that he did not want to die. He said he wanted to be released from prison (which was due to happen seven days later) and was making plans for his future. Staff also told us that Mr Dealey's presentation had improved since the ACCT was first opened.

90. Two days earlier, on 28 July, Mr Dealey was presenting as extremely distressed. He barricaded himself in his cell, attached makeshift armour to his torso and made cuts to his arms. A CM recorded that "…it was evident Mr Dealey was suffering a rapid deterioration in his mental health or he was experiencing drug psychosis. Mr Dealey is massively paranoid about everyone and very anxious about his impending release". We consider that there were ongoing risk factors that had not been reduced to the extent that justified ACCT closure, including self-harm, anxiety about release and uncertainty around his accommodation on release. Before this move onto the inpatient unit, Mr Dealey had withdrawn from the regime and self-isolated for nearly two weeks and had a pattern of doing so.

91. Staff said that the fact that Mr Dealey would receive standard hourly welfare observations in the inpatient unit was a factor in the decision to close his ACCT. The observations in place on the inpatient unit and ACCT monitoring are not comparable and the hourly checks should not have been relied upon as an alternative method of monitoring Mr Dealey's welfare.

92. Mr Dealey's ongoing risks might have been managed by ACCT post-closure monitoring, which is required by policy but was not utilised for Mr Dealey. This was a missed opportunity to ensure that ending ACCT monitoring was appropriate.

We make the following recommendations:

- **The Governor and Head of Healthcare should ensure that ACCT reviews thoroughly assess the risk presented by individuals and only approve closure where there is robust evidence that risks have reduced.**
- **The Governor and Head of Healthcare should remind all disciplinary and healthcare staff of the difference between standard inpatient healthcare observations and ACCT monitoring procedures, to ensure they are not viewed as alternatives.**
- **The Governor and Head of Healthcare should remind disciplinary and healthcare staff to complete the ACCT post-closure section, to ensure that any ongoing risks are appropriately monitored, and the ACCT is reopened where needed.**

93. Mr Dealey self-isolated from 20 July 2021 until his death and told staff he intended to do so until his release. He was highly anxious and paranoid about his safety during this time. We requested a copy of Mr Dealey's self-isolation record but did not receive it. We accept that there was not much more they could reasonably have done to assist him in the circumstances, and that Mr Dealey was being supported by the ACCT process for a period, which will have helped to explore the

deterioration in his mental health. However, it is important that isolating prisoners are monitored, to ensure support can be provided and risks can be managed.

94. We note the transfer requests made by Swaleside, in order to reduce the impact of the transition for Mr Dealey, following his release. We commend the decision taken by staff to move Mr Dealey to the inpatient unit rather than the Care and Separation Unit (CSU). We consider that the CSU was not appropriate for Mr Dealey, who was experiencing a mental health crisis. However, we also consider that the cell he was moved to in the inpatient unit (cell number 5) was not appropriate either. The HCA told us that he had reported his concerns about cell 5 in the inpatient unit. He was concerned about the limitations on visual observations caused by the flap system on the door, which was different to the standard hatch structure and provided little view into the cell. We make the following recommendations:

- **The Governor and Head of Healthcare should review the suitability of cell 5 in the inpatient unit for prisoners who are vulnerable.**

Emergency response

95. Mr Dealey had been in the same position on the floor of his cell for several hours before the HCA realised something was wrong. We understand from interviewing him that he did not raise the alarm sooner because Mr Dealey was not on suicide monitoring, and he thought he was just sleeping. In interview, he told us that prisoners sleep in many different positions, including on the floor, and he did not think it was unusual for Mr Dealey to be lying in this way, especially considering his recent erratic behaviour.

96. The hourly checks undertaken by healthcare staff on the inpatient unit are basic visual checks and are not comparable to the welfare checks completed under the ACCT process. In contrast to the ACCT welfare checks, there is no guidance about how these checks should be completed. We consider that some form of guidance would be helpful to ensure that healthcare staff are clear of the purpose of the check, able to spot potential issues and act appropriately if required.

97. We therefore recommend:

- **The Head of healthcare should issue guidance to staff on the inpatient unit that clearly explains the purpose of and expectations for hourly observations.**

Preparation for release from prison

98. Mr Dealey’s behaviour seemed to deteriorate in the weeks leading up to his release, which he said he was anxious about. Mr Dealey’s offender supervisor had not yet been able to secure him accommodation on release. In interview, staff told us that because Swaleside is not a resettlement prison, and because Mr Dealey was not local to the area, there were additional challenges with finding housing.

99. On 30 July, Swaleside sent urgent transfer requests to HMP Lowdham Grange and HMP Leicester, which were the closest prisons to Mr Dealey’s home area that he was due to be released to. They were keen to reduce the length of his journey

home, which they felt would help reduce his anxiety, the risks for his safety and potentially his offending. They were not able to secure a transfer for him.

Substance misuse

100. Despite Mr Dealey's documented substance misuse history and evidence that he may have been in debt to other prisoners, he was not referred to the substance misuse team until 11 July 2021. This was around 10 months after he had arrived and weeks before his release. We interviewed a drug and alcohol practitioner at the Forward Trust, and she told us that Mr Dealey was completely unknown to the team until 30 July when she attended his ACCT case review. She told us she had no idea why Mr Dealey was not referred to the Forward Trust.

101. This was a serious oversight during Mr Dealey's initial screening. We found no evidence that Mr Dealey's presentation was linked to drug use, but this was a key area of need that should have been supported during his time in prison.

- **The Governor and Head of Healthcare should ensure that prisoners with a history of substance misuse are referred to the substance misuse team on arrival, to enable them to access the appropriate support.**

Meaningful contact

102. One of the main aims of the Key Worker Scheme was to improve prisoner safety through meaningful contact with a consistent member of staff. The scheme usually requires 45 minutes of key work per prisoner per week, delivered by a named officer. However, during the time that Mr Dealey was at Swaleside, COVID-19 was having a significant impact on staffing and an Exceptional Delivery Model (EDM) was in place. This EDM required governors to prioritise the most vulnerable prisoners for key work.

103. Prison records show that no key worker sessions were offered to Mr Dealey for over five months, between 28 September 2020 and 3 March 2021, due to the EDM. Mr Dealey's allocated key worker between March and July 2021 told us that instead of structured and diarised sessions with Mr Dealey, he had to try to find extra time to spend with him as and when he could. Mr Dealey was not assessed as vulnerable in the context of the EDM on key work and so was not prioritised.

104. In interview, staff commented on how low staffing levels meant that they did not always have the time to properly engage with Mr Dealey's complex needs. A CM told us that G wing staff were 'run ragged' and that this might have meant Mr Dealey did not receive the level of support he needed or the one-to-one staff attention that might have helped them to better understand his needs.

105. We do not consider that there was anything more the Governor could have done in the circumstances. We note that the EDM was stood down in April 2022 and hope that staffing numbers are increasing at Swaleside following the pandemic, which will in turn improve safety.

Other learning

106. The attempt to resuscitate Mr Dealey, who was displaying clear signs of death, was not in line with National Resuscitation Council guidelines. We recognise how difficult it must be for officers and healthcare staff to respond in these circumstances, but it is important that they are aware of the actions they should and should not take.

Inquest

107. The inquest, held on 6 November 2023, concluded that Mr Dealey died by suicide.

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