

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in April 2013 at
HMP High Down**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution
to safer, fairer custody and offender supervision'*

This is the investigation report into the death in April 2013 of a man at HMP High Down. He died from an overdose of prescribed medication. He was 50 years old. I offer my condolences to his family and friends.

A clinical review into the care the man received at High Down was carried out. The prison cooperated fully with the investigation.

The man was by most accounts a private man, who talked to only a few other prisoners on his houseblock. While some of his friends thought he was depressed, they did not think he would take his own life and none of them reported their concerns to staff. The only member of staff he confided in was the library manager. He told him about events in his life that were making him feel depressed, but said he was getting help and seeing a psychiatrist, which he was not. He did not seek any extra help or support.

I am concerned that on the man's arrival at High Down, a number of factors which could have identified him as at risk of suicide do not appear to have been recognised and suicide prevention procedures were not started. A mental health referral went astray and further opportunities to refer him to the mental health team which might have provided appropriate intervention were missed. The investigation also raises a number of concerns over medicine management. More generally, there is little evidence that prison officers had any meaningful contact with him or that the prison's personal officer scheme was effective, which meant staff were unlikely to identify any change in his behaviour or attitude which might indicate an increased risk.

Whether any of these issues would have changed the outcome for the man cannot be known but it is a serious matter that a number of processes designed to support prisoners at risk did not operate as they should have done.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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SUMMARY

1. The man was 50 years old when he died in April 2013, at HMP High Down, from an overdose of prescribed and non-prescribed medication. He had been arrested on 11 July 2012 and was remanded into custody at High Down two days later, charged with a violent offence against his wife. When he arrived he told healthcare staff that he had high blood pressure. He said he had a history of depression and taking overdoses and had previously stayed in a psychiatric unit. He was referred to the mental health in-reach team, but the referral was not sent as the healthcare assistant did not use the correct function on the electronic medical record system. Two further opportunities to refer him to the in-reach team were also missed. Despite his history of overdoses, he was allowed to keep his medication in his possession.
2. The man began working in the library. He seemed to enjoy the work and spoke to the library manager about his life. He was convicted in October. From November 2012 onwards, because of a previous conviction, he was not allowed to have contact with his children. His wife also requested that he should not be allowed to contact her. He was upset about this. On 23 November he was sentenced to 20 months and two weeks imprisonment.
3. After Christmas the man stopped working in the library so often and told the manager that he was suffering from headaches and migraines. Nurses gave him paracetamol and ibuprofen on several occasions. Early in 2013, he was told that he could not appeal against his sentence and that his daughter had been placed in foster care. Other prisoners thought that he was very depressed at this time but did not tell staff. He did not tell prison staff how he was feeling and there are no records of any conversations with his personal officer.
4. In April, the man collected his monthly in-possession medication (an anti-depressant and medicines to help lower blood pressure). He appears to have taken all the prescribed medication along with some other medication, during the night of 7/8 April. An officer found him collapsed on the floor of his cell at 5.30am. The officer was unsure about the emergency procedures but immediately contacted one of the night orderly officers. The officer in charge of the prison heard the radio call and issued a code red emergency which ensured an ambulance was called automatically. Staff entered the cell a few minutes later and tried to resuscitate him and continued until paramedics arrived. He was pronounced dead at 6.43am.
5. The man was not assessed as a risk of suicide and self-harm when he arrived at the prison although he had a number of risk factors which should have caused staff concern. He should have been seen by the mental health team but a referral was not properly actioned. As he had a history of overdoses, we are concerned that he was given his medication to keep in his own possession. Although not associated with his death, he was also given large quantities of painkillers without being reviewed. We are concerned that residential staff had little apparent knowledge of him and

that there were no personal officer entries in his record after his induction nine months earlier. There is also a need to ensure that night staff are fully aware of emergency procedures which comply with up to date Prison Service requirements.

THE INVESTIGATION PROCESS

6. Notices were issued at High Down announcing the investigation to staff and prisoners, asking anyone with relevant information to contact the investigator. No one came forward.
7. The investigator visited High Down on 12 April. She visited the wing where the man had lived and collected all of the documents relating to his time in custody. She interviewed staff and prisoners at High Down on 14, 15 and 16 May 2013. She gave preliminary feedback on the findings of the investigation to the Governor.
8. The local Primary Care Trust (PCT) appointed a clinical reviewer to review the man's clinical care. She was given all the relevant documents to assist her review.
9. A copy of the investigation report has been sent to HM Coroner for Surrey.
10. One of the Ombudsman's family liaison officers wrote to the man's family to let them know about the investigation and invited them to identify issues they wished the investigation to consider. No response was received. The family received a copy of the draft report. They raised one issue which they will be taking up directly with the relevant agency.

HMP HIGH DOWN

11. HMP High Down is a local prison near Sutton which holds around 1,100 male prisoners. Healthcare services at the prison are commissioned by NHS Surrey and provided by Virgin Care Services. There is a 23 bed inpatient unit.

Her Majesty's Inspectorate of Prisons

12. The last inspection of High Down was in July 2011. Inspectors judged that healthcare provision was very good. They said the large mental health in-reach team provided a good secondary care service that was well integrated with primary mental health care and the healthcare appointment system worked well.
13. Inspectors found that, for most prisoners, the environment was decent and relationships with staff good. They considered the personal officer scheme was developing and reasonably effective.

Independent Monitoring Board report

14. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In their latest published annual report the IMB reported their concerns that staff did not have enough time to fulfil their roles as personal officers, and said that the scheme had "largely gone to the wall". They described the provision of healthcare as excellent, and commented that the mental health in-reach team played an important role in the prison.

Previous deaths at High Down

15. We have investigated a number of deaths at High Down, which were mostly from natural causes. In one investigation, we found that the member of staff who discovered the prisoner in a collapsed state did not know how to raise the alarm properly and did not use the emergency code system. We have similar concerns in this case.

KEY EVENTS

16. The man was arrested on 11 July 2012 in connection with an allegation of violence against his wife on 1 July. He was remanded from a magistrates' court on 13 July 2012 and taken to HMP High Down.
17. A healthcare assistant completed a reception health screen. She noted that the houseblock nurse would need to see the man because he had a high blood pressure reading of 162/113 (normal levels are between 100-140 for the first reading and 60-90 for the second). She also wrote on his electronic prison medical record (known as SystmOne) that he had spent some time in a psychiatric hospital 18 months earlier and had last seen a psychiatrist six weeks previously. He told her that he suffered from depression for which he took mirtazapine. He said that he did not have any current thoughts of suicide or self-harm. She filled out a referral form to the mental health team. She noted he had been in prison before. A prison doctor saw him and prescribed propranolol (a non selective beta blocker used to treat hypertension, anxiety and panic), mirtazapine (an anti-depressant) and ramipril (for high blood pressure).
18. Although the healthcare assistant wrote in SystmOne that she had made a mental health referral, she did not complete a 'task' (an e-mail or note) on SystmOne. Because of this, the mental health team did not receive the referral. The mental health team never saw the man during his time at High Down.
19. A few days later, a nurse recorded the man's blood pressure as 137/96 (still high but better than the reading of a few days earlier) and his pulse at 109 (just above the normal range). An associate practitioner (a member of the clinical support team) saw him on 17 July in a chronic disease clinic for hypertension. She noted that his blood pressure was still fluctuating and decided to monitor him every two weeks. She gave him some lifestyle advice about smoking (he smoked 4 to 5 cigarettes a day), exercise and diet and noted his condition was aggravated by stress and anxiety. He also had a family history of high blood pressure.
20. On 20 July, the man's personal officer noted in his electronic prison record that he had completed his induction. This is the only personal officer entry in the record.
21. The man was given ibuprofen (an anti-inflammatory and pain killer) and paracetamol for dental pain on 28 July. On 30 July he saw a nurse and asked to have his mirtazapine increased because of the additional stress and worries caused by being in prison. The nurse advised that he wait a week for a further review.
22. A nurse saw the man on 5 August about his depression. She noted that he felt worst at the weekend when he had less to do. He said he had begun to feel helpless and low in energy and that he tried to keep himself busy by doing crosswords, reading and helping other people with their homework from

education classes. She noted that he was taking 30mg of mirtazapine and referred him to see the GP about an increase. On 6 August, a doctor maintained the prescription of 30mg of mirtazapine but, on 9 August, another doctor prescribed an additional 15mg and noted that he took 30mgs at night. He also prescribed 7.5mg zopiclone (for insomnia) for three nights.

23. On 14 August 2012, the man saw a nurse about a small cut inside his mouth after he had been assaulted by another prisoner. He explained that he had been hit hard and then fallen. (This incident was followed up by staff and CCTV identified the prisoner who had attacked him. The matter was then referred to the police.)
24. A nurse completed an in-possession medication assessment on 28 August, to assess the man's suitability to keep his medication in his cell. He was assessed as suitable and thereafter given his medication in monthly doses to take as prescribed. (There was no reference on the risk assessment noting that he had previously taken overdoses of medication.)
25. From 5 September, the man worked full time in the prison library. He was a trusted prisoner and his library orderly pass gave him access to any of the houseblocks. The library manager talked to him in the course of his work and said he knew him reasonably well.
26. The dentist saw the man on 10 September. He told her that some of his teeth had been fractured in the assault on 14 August. The dentist listed him for follow up for treatment, including fillings. During the next few months he was given repeated doses of paracetamol and ibuprofen by nurses when he requested them.
27. The man had a previous conviction from 2003 for possessing and making indecent images of children. On 6 November, he was barred from contacting any children, including his daughter. His wife asked Sutton Social Services to ensure that he did not contact her. Procedures were set up by the prison to monitor his mail from 8 November onwards.
28. A probation officer wrote a pre-sentence report after the man was convicted on 12 October. As part of her assessment she interviewed him in High Down. She noted that although he said he did not have any current thoughts of self-harm or suicide, this remained an ongoing concern and should be monitored. He told her that the mental health in-reach team at the prison had decided not to see him because his depression did not warrant any intervention from them. She contacted the mental health in-reach team who said they had not had a referral, but that if they had, they would have seen him and carried out an assessment. The mental health team did not go and see him as a result of this conversation or check his medical record which would have indicated the missed referral.
29. On 23 November, the man was sentenced to 20 months and two weeks imprisonment.

30. A doctor reviewed the man's medication on 29 November. He said he was getting about four hours sleep a night. The doctor decided to leave his medication as it was because he said he had tried several other antidepressants in the past.
31. The library manager told the investigator that around Christmas time he noticed a change in the man. He thought it coincided with the fact that he was not allowed to contact his wife or daughter anymore. He had been recording story CDs in the library as part of the Storybook Dads facility (a scheme which allows father to record stories which can be played to their children at home). He said that when prison staff told the man that he would not be able to send these out anymore, it affected him and he became depressed.
32. The man sent a box of presents and a card to his wife's address on 20 December. Sutton Social Services contacted the prison to tell them that the mail monitoring procedures had not worked.
33. On 28 December 2012, a nurse gave the man 16 paracetamol tablets and advised him to take one or two four times a day. She did not record a reason in the medical record, but told the investigator that she usually gave it for conditions such as toothache or backache.
34. The man saw a nurse on 12 January 2013 as he said he had been feeling unwell during the last couple of days. She gave him ibuprofen and paracetamol for a headache. The next day, she checked his blood pressure. He told her he had knocked his head against a wall or maybe fallen down and she saw a bruise over his left brow.
35. The man completed the Alcohol Awareness accredited programme in January and appealed against his sentence.
36. The man was given more paracetamol and ibuprofen tablets when he requested them on 31 January, 7 February, 8 February and 7 March. In total he was given 48 paracetamol and 16 ibuprofen during this period.
37. On 11 March, the man told a nurse that paracetamol was not effective pain relief for his headaches. A doctor then prescribed some Migralve (migraine) tablets for him.
38. The library manager said the man always talked about his daughter in a very loving, positive way. He said he showed him a letter about a court hearing about his daughter going into local authority care. He was not able to represent himself at this hearing. A decision was then made for his daughter to go into care, but it is not clear when. Although the prison monitored his mail to check he was not having contact with children, they did not record the contents of the letters he sent or received. The library manager said this was when he became depressed and he began to complain about having migraines. He said the man would often ask to leave halfway through a morning session because of a bad migraine. During March, he did not work in

the library very much. The library manager said houseblock staff were aware that he was not going to work because of migraines.

39. Towards the end of March, the man began working in the library more often. He told the library manager he was seeing a psychiatrist. He did not think the man would do anything to harm himself and thought he was due for release soon. He said he would have felt confident about opening an ACCT (the Prison Service suicide and self-harm prevention process) if he had been worried that the man might have harmed himself.
40. A doctor wrote a repeat prescription for the man on 5 April. He was given 28 mirtazapine tablets, 84 propranolol tablets and 28 ramipril capsules. He collected them on 6 April.
41. A Senior Officer (SO) was working on houseblock 3 on Sunday 7 April. After the teatime meal he remembered speaking to the man outside his cell. He thought he seemed to be his usual self and had a laugh and a joke with him. The SO described him as "quite upbeat". He said he seemed to be happy and that no members of staff on the houseblock considered him a suicide risk.
42. An operational support grade (OSG) was on duty on houseblock 3 for the night period and began work at 8.30pm. He conducted a roll check to ensure all prisoners were in their cells when he came on duty and then patrolled the houseblock periodically, answering cell bells and checking prisoners who were being monitored under suicide and self-harm prevention procedures. He said the houseblock can be quite noisy for a time with music and televisions and people talking through the windows, but is quieter after midnight. The OSG did not check on the man during the night and said he did not hear any unusual noises. He did not press his cell bell at any time that night.
43. Around 5.30am, the OSG began the early morning roll check and count. When he looked into the man's cell he saw him lying face down on the floor. His head was underneath the bed and the light was on. He knocked on the cell door and shouted to him, but got no response and could not see his chest well enough to see if it was moving. He then radioed the assistant night orderly officer and asked for immediate assistance. He did not open the cell door.
44. The night orderly officer (NOO) in charge of the prison heard the radio call. When the OSG told the assistant NOO that the man could not be roused, she immediately (at 5.37am) issued a code red radio message (which means that there is a life-threatening emergency and requires the control room to call an ambulance). The NOO went to houseblock 3 and arrived with the assistant NOO and an officer a couple of minutes after the OSG's message. The NOO saw the man lying face down on the floor, opened the cell and they went inside. He saw what looked like vomit on the bed and the remains of an orange and white medicine capsule. The staff pulled him from under the bed and turned him over.

45. The NOO said the man's lips had no colour, his eyes were partially open and there was vomit around his mouth. The staff began cardiopulmonary resuscitation (CPR). The assistant NOO used a face mask and started to give rescue breaths to him. The officer gave chest compressions. They checked that the control room had called an ambulance. After a few minutes, Nurse A arrived followed by Nurse B.
46. When Nurse B heard the code red, she picked up an emergency green bag and walked as quickly as she could to houseblock 3. She did not know the nature of the emergency she was responding to, but was told it was serious when she got to the wing. She asked an officer to get the houseblock red emergency bag (which contains an ambu-bag and defibrillator) while she collected a blood monitoring machine, from the treatment room next door. When she went into the cell the man was lying on his back on the floor and the assistant NOO was giving CPR. She told the investigator that the man did not respond, was not breathing and had no pulse. He was pale, his lips and fingertips were blue and he was cold to the touch but she thought that she should try to resuscitate him. The defibrillator was attached to him but advised not to shock and to continue chest compressions. (A defibrillator delivers electric shocks to restart the heart when a shockable rhythm is detected.)
47. Nurse A took over doing chest compressions and the assistant NOO continued giving breaths. Nurse B checked the man's blood sugar level (which was low) and the pulsometer did not give any reading for a pulse or oxygen level. She went to the treatment room to print off his medical history to see if that would help them identify why he had collapsed. As she passed the houseblock office she was asked to speak to the paramedic control room by telephone to update them on the situation. She then returned to the cell and took over chest compressions.
48. Three paramedics (in an ambulance and rapid response vehicle) arrived at High Down at 5.59am and got to the cell at 6.05am according to the ambulance report form. (The time was not recorded in the prison gate book.) The paramedics took over resuscitation efforts and continued for some time. They administered adrenaline. He did not show any signs of life at any point. After discussing the situation with the on-call doctor, the paramedics decided to stop at 6.43am and he was pronounced dead. In the ambulance report form, the paramedics noted that he was in asystole (no cardiac electrical activity) throughout, his skin was pale and cyanosed (a blue colour, which suggests a lack of oxygen in the body) and there was stiffness in his face and neck which might be the beginning of rigor mortis.
49. The man left some letters in his cell. In the letters he said "its best for everyone" and that he had "nothing to live for".
50. The duty governor held a hot debrief for staff who had been involved in the emergency. Staff who had been involved were offered support from their managers and members of the care team.

51. A post-mortem examination toxicology report showed that the man had died from an overdose of mirtazapine and propranolol. He also had the following drugs in his system after his death: paracetamol, codeine, olanzapine, propranolol, mirtazapine, amitriptyline and ibuprofen. (Ramipril was not within the range of substances tested for.)
52. The results of the toxicology tests were interpreted by a forensic toxicologist. She said the low concentrations of paracetamol and codeine detected in the blood would be consistent with therapeutic use and did not indicate an overdose of these drugs prior to death. She also said that the low concentrations of olanzapine, amitriptyline and ibuprofen detected in the post-mortem blood would be consistent with therapeutic use.
53. Olanzapine is an antipsychotic drug and amitriptyline is an antidepressant. Neither of these drugs was prescribed to the man. It is not clear how he obtained the medication but his job in the library brought him into contact with many prisoners, some of whom would have been prescribed them.

Family liaison

54. A Senior Officer (SO) was appointed as the family liaison officer. She visited the man's wife's home with a social worker but did not get any answer. Social Services contacted the man's wife later that day. The social worker, the SO and a church family support worker then went to see her and the SO broke the news of his death about 6.00pm that evening. The man's wife passed on other family contact details and it was decided that his sister would act as contact with the prison.
55. In line with national policy, High Down offered to contribute towards the funeral expenses. A memorial service was held at the prison. The man's sister accepted an invitation to visit High Down.

ISSUES

Clinical care

Mental health care

56. The man was prescribed mirtazapine (an anti-depressant) throughout his time in High Down. His dose was increased from 30mg per day to 45mg in September. He saw a doctor at the end of November for a review of his medication. It was left unchanged as it was noted that he had tried other antidepressants in the past.
57. Guidelines issued by the National Institute for Clinical Excellence (NICE) on reassessing people prescribed antidepressants, state that patients should be reassessed every two to four weeks for the first three months of treatment. The man was already using antidepressants when he arrived at High Down. However, even when the dosage was increased, he was not reviewed again until November, and not after that. We believe that he should have been reviewed more frequently. A review might have considered the need for a referral to the mental health team. We make the following recommendation:

The Head of Healthcare should ensure that prisoners who have been prescribed antidepressants are reviewed in line with NICE guidelines.

58. During the reception screen on 13 July 2012, the healthcare assistant wrote on SystmOne, the electronic medical record, that the man had spent some time in a psychiatric hospital and had last seen a psychiatrist six weeks earlier. He told her he suffered with depression and took mirtazapine. She filled out a referral form for the mental health in-reach team.
59. Although the healthcare assistant completed the form, no 'task' was done and the referral was not acted upon by the mental health in-reach team. The in-reach team did not see the man at any time while he was in High Down. The clinical reviewer said the system in the community for making a referral to the mental health in-reach team would be very clear and would ensure follow up. She said a successful referral might have led to a review of his medication by mental health clinicians, an estimation of risk assessment with an associated risk management plan put in place and ongoing reviews to see if he would benefit from psychotherapy.
60. Further opportunities to seek a mental health review were missed. The man's community GP sent a summary of his issues and medication on 19 July 2012, which said that he had a "special forensic history", had taken various overdoses and was seriously depressed. He had taken his last overdose on 14 June 2012. The summary was scanned into SystmOne but it is not clear if a GP saw the summary. The primary care clinical lead told the investigator that since October 2012 all information from community GPs is shown to the prison GP, who signs the page to show they have read it before it is scanned. Had a prison GP seen the summary, they might have decided to make a referral to the in-reach team.

61. A probation officer saw the man when writing a pre-sentence report in November 2012. He told her he had asked to see the in-reach team but had been rejected because his depression did not warrant their intervention. She contacted the in-reach team at High Down to check this and they told her they had not had a referral. They told her that, because he had previously been a mental health in-patient, they would, at the very least, have seen him if he had been referred and done an assessment. (She said in her report that she was therefore unsure if he was misleading her or whether he had been given the wrong information). We consider that the mental health in-reach team should have acted at this stage. As she had given them important information about his past they could have decided themselves to see him to carry out an assessment or at the very least consulted his records, when they might have seen the initial referral which they had not received.
62. We cannot be certain that the man would have benefited from input from the mental health in-reach team. However, it is clear that a referral system error meant that the original referral was not received. Further opportunities for mental health input were missed, both by GPs and the mental health in-reach team itself. We make the following recommendation:

The Head of Healthcare should ensure that staff complete all actions when making referrals to the mental health in-reach team and that all healthcare staff direct patients to the mental health in-reach team whenever there is information indicating that a mental health assessment is required.

Risk assessment for in-possession medication

63. The aim of the policy for in-possession medication at High Down is to:
- increase the number of patients in prison who hold and have responsibility for their own medicines and
 - to have robust risk assessment tools in place to minimise the risk of self-harm and trading.
64. All prisoners are given responsibility for their own medication (apart from certain types of controlled drugs) unless there are clearly identified factors why this should not be the case. These factors include whether the patient is on an open ACCT; any suicide attempts in the past two months; any history of non-compliance with taking medication in the past two months; concerns about the patient's ability to follow instructions about taking medication; any information to suggest the patient is being bullied or bullying others for medication and whether the mental health team have raised concerns. The pharmacist told the investigator that 60 – 70% of prisoners hold their medication themselves.
65. The man's assessment on 28 August 2012 was done by a nurse, who judged him suitable to hold his medication in possession. He signed the patient agreement. The nurse technically followed the policy in that his most recent overdose had been on 14 June, just outside the two month window.

However, in our opinion, his overdose of June 2012 should have been taken into account as part of the risk assessment particularly as his GP had indicated that he had taken a number of overdoses previously which would suggest a significant risk. We make the following recommendation:

The Head of Healthcare should ensure that in-possession risk assessments take into account a prisoner's full history of overdose.

Over the counter medication policy

66. The policy for the use of "over the counter" medication at High Down states,
- "Only registered nurses and appropriately trained health care assistants can issue over the counter medicines in accordance with these guidelines and after nurse triage... The nurse must enter details of the 'over the counter' (OTC) medicine provided and the reason for its issue on SystemOne using the 'one-off' facility.
- "A record should also be made in the patient's notes of:
- Reason for administration
 - Drug and amount given
 - Time/Date given".
67. The policy continues that paracetamol can be given for the management of mild to moderate pain as assessed using the nurse's clinical judgement. According to his medical record, the man received 16 tablets of ibuprofen on 14 December, 12 January and 7 February (48 tablets in total). He was given 16 tablets of paracetamol on 28 December, 12 January, 31 January, 8 February, 7 March and 31 March (96 tablets). Staff only recorded the reasons for issue on 12 January.
68. The clinical reviewer considered that in a custodial setting a review should have been held to establish why the man required such a high level of pain relief. Although he did not overdose on his pain relief medication, paracetamol, in particular, can be dangerous when taken in excessive quantities, and she thought that this should be taken into account when issuing non-prescription drugs. It is important that the reasons for issue are recorded, as this might help staff decide whether a review is necessary. We make the following recommendation:

The Head of Healthcare should ensure that staff follow the policy on the issue of over the counter medication and that a prisoner's use of such medication is monitored effectively.

The man's risk of self-harm

69. When the man arrived at High Down he had a recent history of self-harm (an overdose) had committed an offence against his wife, had been treated in a psychiatric hospital and was being treated for depression. All of these are risk factors that should be taken into account when assessing the risk a prisoner

might pose to themselves. Although it was noted that he said he had no thoughts of suicide and self-harm we believe that these risk factors suggest that he was at risk of self-harm when he arrived at High Down, and that staff should have opened an ACCT as soon as he arrived. There is no indication that these risk factors were considered when he first arrived. Had an ACCT been opened he might have received the initial support he needed. We make the following recommendation:

The Governor should ensure that all the known risk factors of a newly-arrived prisoner are fully considered when determining their risk of suicide and self-harm and that an ACCT is opened when there is an indication that the prisoner is at risk.

70. During his time at High Down, the man was barred from contacting his daughter or having any contact with his wife. He referred to this lack of contact in the notes he left in his cell. The probation officer noted her concerns about ongoing self-harm when she saw him in November 2012. The library manager noted that he became depressed around Christmas time. He also told other prisoners about his personal issues, but the prisoners did not share this information with staff and two of them told the investigator that they did not realise that he was planning to harm himself.
71. In the absence of a mental health overview, none of these indicators of increased risk seem to have been considered. However, as the man was not being monitored for possible suicide or self-harm, there were limited opportunities for staff to recognise these indications. Other prisoners knew about his issues, but he seemingly had little contact with his personal officer or other officers on the wing. There were no personal officer entries in his record after July 2012. The Governor told the investigator that he did not think that the personal officer scheme was workable at a local prison such as High Down.
72. It is of course possible that, even if the personal officer scheme was working well, the man would not have engaged with staff and told them how he was feeling. However, where the scheme works well, it provides an opportunity for prisoners to alert staff to issues should they want to but, crucially, also for staff to get to know a prisoner and to be able to spot any changes in their demeanour. Despite the Governor's views, High Down's own policy stresses the importance of an effective scheme supporting prisoners and treating them decently. The turnover of prisoners in local prisons such as High Down can make such schemes difficult, but he had been at the prison for nine months with no indication of any supportive entry from a personal officer or other member of staff in that time. The apparent lack of staff interaction with him is a concern as this makes it difficult to identify any change in behaviour or attitude which would indicate an increased risk. We make the following recommendation:

The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme which ensures that officers get to know prisoners and identify their needs

backed up by regular case history notes.

Emergency response

73. High Down's local operating procedure states that the member of staff who discovers an apparent death must raise the alarm and request local emergency clinical assistance immediately. There is no reference to using an emergency code. The operating procedure gives detailed instructions on the circumstances in which staff should consider entering a cell at night and highlights that the saving of life is paramount. The procedure also states that the personal safety of staff should be considered before they decide to enter a cell.
74. The OSG was not confident about what he should have done when he found the man collapsed in his cell. He told the investigator he had not had any specific training about doing a night shift in the prison and that, although he carried a cut down knife, he did not know how to use one. He said he carried a cell key for use in emergency situations, but did not think about entering the cell and would not feel confident about going in.
75. We do not criticise the OSG for not entering the cell immediately. When found, the man was lying face down with his head under the bed and it was unclear whether he was breathing or not. However, in other situations, for example if a prisoner is found hanging, it would be appropriate to enter the cell as quickly as possible after raising the alarm. It was clear during interview that the OSG would not have done this and was unclear about what radio message to make.
76. The Governor told the investigator that some training had been done for night staff so they knew what to do in an emergency, but the OSG had not had this training.
77. High Down's emergency procedures do not refer to the use of a specific emergency code. Prison Service Instruction (PSI) 03/2013, issued in February 2013, gives a mandatory instruction to governors that they should ensure that a medical emergency response code protocol exists that enables staff finding a prisoner in a life-threatening situation to clearly and concisely convey the nature of the medical emergency simultaneously and to all interested parties and contact the communication and control room. It is a concern that, two months after the issue of the instruction, High Down's emergency procedures did not comply with the mandatory requirements of the PSI and that a member of night staff on duty had so little understanding of emergency procedures. We make the following recommendation:

The Governor should ensure that High Downs' emergency procedures are in line with PSI 03/2013 and that all staff, including those working at night, are trained and understand their responsibilities in an emergency.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that prisoners who have been prescribed antidepressants are reviewed in line with NICE guidelines.
2. The Head of Healthcare should ensure that staff complete all actions when making referrals to the mental health in-reach team and that all healthcare staff direct patients to the mental health in-reach team whenever there is information indicating that a mental health assessment is required.
3. The Head of Healthcare should ensure that in-possession risk assessments take into account a prisoner's full history of overdose.
4. The Head of Healthcare should ensure that staff follow the policy on the issue of over the counter medication, and that a prisoner's use of such medication is monitored effectively.
5. The Governor should ensure that all the known risk factors of a newly-arrived prisoner are fully considered when determining their risk of suicide and self-harm and that an ACCT is opened when there is an indication that the prisoner is at risk.
6. The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme which ensures that officers get to know prisoners and identify their needs backed up by regular case history notes.
7. The Governor should ensure that High Downs' emergency procedures are in line with PSI 03/2013 and that all staff, including those working at night, are trained and understand their responsibilities in an emergency.

ACTION PLAN: The Man – HMP Highdown

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that prisoners who have been prescribed antidepressants are reviewed in line with NICE guidelines.	Accepted	SystemOne has been modified so that when the patient has been on an anti-depressant for 6 months, a prompt will appear on the system asking the GP to perform a medicines review, which will determine if the anti-depressant needs to be continued.	Completed	
2	The Head of Healthcare should ensure that staff complete all actions when making referrals to the mental health in-reach team and that all healthcare staff direct patients to the mental health in-reach team whenever there is information indicating that a mental health assessment is required.	Accepted	On SystemOne there is a referral template in place to enable any member of healthcare staff to refer a patient directly to the mental health in-reach team and this is actioned on the day by the duty nurse. Two templates are available; a short one and a more detailed form. The completion of templates forms are part of the SystemOne induction training and refresher training.	Completed	

3	The Head of Healthcare should ensure that in-possession risk assessments take into account a prisoner's full history of overdose.	Accepted	The risk assessment has now been adapted to include a question which asks about the prisoner's full history of overdose, distinct from the recent history i.e. last two months of suicide overdose attempts.	Completed	
4	The Head of Healthcare should ensure that staff follow the policy on the issue of over the counter medication, and that a prisoner's use of such medication is monitored effectively.	Accepted	Clinical staff are all trained to use the Home Remedy policy correctly and any home remedies issued are recorded electronically on SystemOne. Clear instructions are detailed on every home remedy packet and instructions are re-enforced during nurse triage. The pharmacy department carry out an annual audit to ensure correct adherence to the Home Remedies Guidelines including adhering to the maximum number of issues per month to each patient.	Completed Audit to be carried out within the next 6 months	
5	The Governor should ensure that all the known risk factors of a newly-arrived prisoner are fully considered when determining their risk of suicide and self-harm and that an ACCT is opened when there is an indication that the prisoner is at risk.	Accepted	Risk factors are determined upon the First Night In Prison (FNIP) process run at High Down. Relevant information is disclosed by Health Care screening staff to prison FNIP staff.	Completed	

6	The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme which ensures that officers get to know prisoners and identify their needs backed up by regular case history notes.	Accepted	High Down does not currently operate a Personal Officer Scheme - previous personal officer schemes ensured regular contact with specific members of staff, who noted conversations on a prisoner's Case Notes on C-Nomis. Wing staff do have contact with prisoners and their needs recorded on ACCT document and case notes	Completed	
7	The Governor should ensure that High Downs' emergency procedures are in line with PSI 03/2013 and that all staff, including those working at night, are trained and understand their responsibilities in an emergency.	Accepted	For the Training Department to ensure that all members of staff are fully aware and receive training on emergency procedures, so that they know how to respond in such cases, in accordance with PSI 03/2013.	March 2014	