



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at
HMP Lowdham Grange in March 2011**

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 a report of an investigation into the death of a man in March 2011 at HMP Lowdham Grange. He was 45 years old when he died in his cell, following a fatal overdose. I extend my condolences to his family and to all those affected by his death.

The investigation was conducted by an investigator. A clinical review into the care provided for the man while he was at Lowdham Grange was commissioned from the local PCT. They appointed a clinical reviewer to conduct the review. I apologise for the delay in producing this report

The man had made at least two attempts to take his own life by the time he arrived at Lowdham Grange in March 2010. On 16 August 2010, he took an overdose in an attempt to take his own life, leaving a suicide note. Staff at Lowdham Grange successfully resuscitated him and he returned to the prison after an overnight stay in hospital. On his return, he was made subject to self harm monitoring procedures (known as ACCT) which he remained on until his death. He was reviewed regularly, and was seen on many occasions by mental health professionals. He was open about his intention to take his own life, and told staff several times about his intention to obtain drugs on the wing. On two occasions, he was found to have secreted medication in his cell.

During a routine check one morning, staff were unable to get a response from him. They entered his cell quickly and called for help appropriately. However, staff and paramedics were unable to revive him.

The investigation found that, in the main, the man was well cared for during his time at Lowdham Grange. In particular, there is evidence that several members of staff built good relationships with him. However, some important information was not recorded in the ACCT and not all staff appeared to have engaged with him as effectively as they might have done. The investigation also raises concerns regarding the timing and supervision of the issuing of medication. He was clear about his intention to obtain illicit drugs on the wing and it is an obvious concern that a prisoner could be so certain about his ability to do so. Finally, the investigation also raises concerns about difficulties faced by him in meeting his dietary needs. Recommendations are made to address all these issues.

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 initially remanded into custody in July 2008. He had previous experience of prison. During a reception healthscreen, he told staff that he had previously tried to hang himself and, three weeks earlier, had taken an overdose.
2. After he was given an indeterminate sentence for public protection, he was located in several different prisons. In 2010, while he was at HMP Lincoln, staff became concerned that he was secreting medication and made him subject to self harm monitoring procedures (known as ACCT).
3. Later that year, he moved to HMP Lowdham Grange. He started to see a counsellor and was offered support from the mental health team.
4. On August 16 2010, he was found unresponsive in his cell after taking an overdose. He had left a suicide note. Another ACCT was opened when he returned from hospital the following day. At the first ACCT meeting, he told staff that he still wanted to die.
5. Over the next few months, the man was regularly monitored by staff and remained on the ACCT. On two occasions, his cell was searched and staff found drugs. On the second occasion, on 7 January 2011, he confirmed that he had secreted the medication in order to take an overdose at a later date. He was removed from his cell and, after a period in the Re-integration Unit (which was formerly known as the segregation unit), moved to a different houseblock.
6. Following this, he had difficulty obtaining milk and meals that were appropriate for his diet (he had been put on a high fibre, low fat diet to address weight problems). It also took several weeks for staff to arrange for an orthopaedic mattress to be brought from his previous location.
7. The man continued to tell staff that he intended to take his own life and, on several occasions, he said that he had been offered drugs on the wing but they were not of sufficient quality.
8. On a morning in March a PCO made a routine check on him and obtained a response from him. Fifteen minutes later, she made another check, but was unable to get a response. She asked another PCO, who was standing nearby, to go into the cell with her. They could not get a response from him and immediately called for assistance. Despite a lengthy resuscitation attempt by prison staff and paramedics, they were unable to revive him. A subsequent post mortem examination confirmed that he had died as a result of a drugs overdose.
9. We make nine recommendations as a result of this investigation. These relate to the ACCT process, the issuing of medication to prisoners, in particular at night, monitoring the availability of drugs at Lowdham Grange,

resolving the issues of prisoners who are on ACCTs and ensuring that those who are on special diets receive appropriate meals.

THE INVESTIGATION PROCESS

10. This office was notified of the man's death on 15 March 2011. An investigator was appointed to lead the investigation which he opened on 21 March, when he visited Lowdham Grange. During the opening visit, he met with representatives from the prison's management team, and the Independent Monitoring Board. He also met with a member of the chaplaincy as well as visiting the man's wing and the cell where he died.
11. The investigator visited Lowdham Grange on 13 and 14 July 2011. He interviewed 14 members of staff. We apologise for the delays in issuing this report, which have been due to workload pressures in this office.
12. A clinical review into the care the man received while he was at Lowdham Grange was commissioned from the local Primary Care Trust. They appointed a clinical reviewer to conduct the review, the final version of which was received by this office in August.
13. The investigator contacted the Coroner for Nottingham to request a copy of the post mortem report. A copy of this report will be sent to the Coroner for his information, and to assist in preparation for the inquest into the man's death.
14. One of our family liaison officers contacted the man's family to inform them of the nature and purpose of this investigation, and to offer them the opportunity to raise any concerns or questions for the investigation to consider. They were concerned he had difficulties with medication, that he was often given the wrong medication at the wrong dose. His family were also concerned he was not given milk as this was to accompany his medication as it would cause nausea if the medication was taken on an empty stomach.
15. The family received a copy of the draft report as part of the consultation process. They made a number of comments and highlighted the following continuing concerns: why the healthcare team was not consistently included in ACCT case reviews; why the doctor was not consulted about alternative medication or delivery methods; why nurses were unaware of the hoarding of medication; and the use of electronic records. His family also questioned whether he was in the prison most suitably equipped to deal with his mental health needs. We have considered the issues raised and they have been clarified in correspondence with the family.

HMP LOWDHAM GRANGE

16. HMP Lowdham Grange is run by SERCO, a private company who run several prisons on behalf of the Ministry of Justice. It is a category B training prison (prisoners are allocated to a certain category depending on factors including risk of escape. Category B is the second highest security category) in Nottinghamshire, and holds over 900 male prisoners. The accommodation is made up of five houseblocks, which typically hold 120-130 prisoners on three or four residential wings. The prison also has a unit called the Re-integration Unit (the RIU), which is the equivalent of the segregation unit in other prisons.
17. Healthcare services are provided by SERCO. Secondary mental health care services (which follow referral from primary health practitioner such as a GP) are provided by the local Primary Care Trust.

HM Chief Inspector of Prisons' report

18. The Chief Inspector of Prisons inspected Lowdham Grange in March 2011, in the same week that the man died. This was a full, announced, inspection, and the report of the inspection was published in May 2011. In his foreword, the Chief Inspector commented specifically about self harm and said:

“Those at risk of self harm were well cared for – although, tragically, during the week of the inspection, the prison suffered what appeared to be its first self-inflicted death in six years.”
19. Speaking more generally, he said that the prison was “an impressively safe and decent place”, that the personal officer scheme was improving and that staff-prisoner relationships were good.
20. In the report, several areas of relevance to this investigation were discussed by inspectors. 71% of prisoners said that they were happy with the personal officer scheme, against a comparator of prisoners in similar prisons of 60%. Inspectors assessed that there was a good level of care for those at risk of suicide or self harm. However, while documentation for those being monitored was generally good, it was less so for “complex cases”. They noted:

“The ACCT documents that we reviewed demonstrated a high level of care for prisoners at risk of self-harm and suicide. It was notable that a number of the ACCTs in our sample were generated by frustration with health care. Multidisciplinary case reviews were regular and well attended: in one case eight members of staff and the prisoner were present. Mental health input was provided in appropriate cases. Prisoners' families were not involved in ACCT case reviews but they were updated with the prisoner's consent. Observation entries were detailed and on the whole reflected meaningful interactions with the prisoners. Post-closure reviews were appropriately documented.”

21. Inspectors also said that “there was some good mental healthcare, but the level of need of services was high”.
22. While commenting on the provision of food, inspectors found that different dietary needs (including vegetarian, vegan kosher and gluten-free diets) were “generally met”. 62% of prisoners said that food was good, against a comparator of 29% in similar prisons.
23. Inspectors also noted that only 18% of prisoners reported that illegal drugs were easy to get hold of. This was against a comparator of 31% in similar prisons.

Independent Monitoring Board report

24. Each prison is required to have an Independent Monitoring Board, members of which are appointed by the Secretary of State for Justice and who are members of the local community. The IMB has access to all parts of the prison, and meets the Director regularly to express any concerns. The IMB is also required to formally report on the prison every year.
25. In their last published report, covering the period February 2010-January 2011, the IMB said that the prison was “managed and operated well”. However, the IMB felt that there was “inadequate psychiatric provision” for the number of prisoners with mental health issues. The IMB noted that since the segregation unit had been renamed the RIU, 30% of prisoners had returned to the wings. This was in contrast to the near 100% of segregation prisons who had been moved on to other prisons.

Previous investigations at Lowdham Grange

26. Since the Ombudsman first started investigating deaths in prison custody in 2004, there have been six deaths at Lowdham Grange prior to that of the man’s. (There was another death shortly before this report was published.) Of these, the previous self-inflicted death was in 2005. The circumstances of that death are different to that of the man’s, and there were no recommendations made then that are relevant to this investigation.

Assessment, Care in Custody and Teamwork (ACCT)

27. ACCT, the Prison Service process for supporting and monitoring those prisoners thought to be at risk of harming themselves, was introduced in 2007. An ACCT plan can be opened by anyone working in the prison if they have any concerns that a prisoner might have tried, or, in the future, might try to harm himself. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of observations (where staff must check the prisoner) and interactions (where staff must have a conversation with the prisoner) are flexible and can be set according to the perceived risk of harm. If staff perceive the risk of harm to

be very high, the prisoner may be constantly observed, with a member of staff positioned outside their cell at all times. Where the perceived risk is lower, the level of observations may be several times an hour or day. Observations also take place during the night.

CARATs - Counselling, Assessment, Referral, Advice and Throughcare services

28. Organisations specialising in the treatment of substance abuse have drugs and alcohol workers based in most prisons. CARATs workers can run programmes, offer counselling, support and referral to rehabilitation centres to prisoners and on release. Access to CARATs is voluntary, by application.

KEY EVENTS

2008

29. On 3 July 2008, the man was remanded into custody at HMP Bedford having being charged with serious offences. During a healthscreen in reception, he gave a urine test which was positive for opiates, benzodiazepines and cocaine. He said that he used a salbutamol inhaler for asthma, and his weight was recorded as 140kg. As his height was 1.85m, he was regarded as being clinically obese. It was also recorded that he had a history of mental health problems. He had previously tried to hang himself and, three weeks before coming in to prison, had taken an overdose. He was allocated to a normal cell and was referred to the prison doctor to review his substance misuse.
30. The doctor saw him the next day. They discussed mental health and substance misuse. He said he used £40 of heroin each day. The doctor planned to prescribe both diazepam (a sedative) and lofexidine (used to help relieve the effects of alcohol withdrawal) as part of a detoxification plan.
31. On 8 July, after appearing at court, the man was moved to HMP Peterborough. Following another urine test, he tested positive for cannabinoids, opiates, benzodiazepines and cocaine, but negative for amphetamines and methadone. The next day, he saw the doctor who noted that he had declined the lofexidine detoxification but had started to decrease the dosage of prescribed medication (he had been prescribed olanzapine (an anti-psychotic drug), diazepam, dihydrocodeine (a strong pain killer) and nitrazepam (which is used to help insomnia) while he was in the community).
32. He was moved to a wing. Three days later, wing staff contacted healthcare to ask when he would be starting on methadone, and saying that he needed a special diet as he was diabetic. Healthcare staff contacted his community doctor and confirmed that, in the previous 12 months, there was no record that he had been diagnosed with diabetes.
33. On 26 August, a mental health nurse at Peterborough spoke to their community equivalent who had looked after the man in the community. The Community mental health nurse confirmed that there had not been any diagnosis of mental health problems, and that his behavioural issues were the result of drug use, anger issues and impulsivity.
34. In September, he was advised to go to the gym to help him lose weight. He was also prescribed tramadol and acupan (both strong pain killers) to relieve back pain. He saw a doctor on 22 September and agreed to reduce the dosage of olanzapine, and to replace diazepam with busiprone. The next month, olanzapine was replaced with quetiapine (a different antipsychotic), and diazepam restarted. However, on 17 October, he said that he was unhappy with his pain control.

35. On 5 December, the man was sentenced at Crown Court. He was given an Indeterminate Sentence for Public Protection (IPP) with a minimum tariff of five years. (An IPP means that the Parole Board will need to agree that the risk the prisoner poses to the public has been reduced to acceptable levels before they are released. This means they might serve longer than the minimum tariff.)
36. He saw a mental health nurse on 24 December. He admitted that he was feeling down because of his sentence, and because he was concerned about his son. He was referred to the CARATs team (Counselling, Assessment, Referral, Advice and Throughcare, a drug service available in every prison).

2009

37. On 18 February, he was placed in a safer custody cell as he had received bad news. (Safer cells are designed to make the act of suicide or self-harm as difficult as possible. This is achieved by reducing ligature points. Specialist “anti ligature” furniture and fittings are installed in the cell.) An ACCT (Assessment, Care in Custody and Teamwork, the methods used in prisons to offer support to those at risk of suicide or self harm) was opened. As part of the careplan, it was decided that he should be observed taking his medication. (It is not clear from the documentation when this ACCT document was closed.)
38. In May, the man’s weight was noted as 149kg (this is down from 160kg the previous September). His medication was noted as including olanzapine (10mg at night), diazepam (10mg), busiprone (a drug used to reduce anxiety) (10mg), quetiapine (300mg) and tramadol (150mg). His asthma also became worse in this month and he was given a salbutamol inhaler. In August, he was put on a high fibre, low fat diet in order to help address weight issues.
39. He was transferred to HMP Lincoln on 28 October. When he saw the prison doctor, the level of tramadol was increased to 300mg daily, because of pain in his coccyx and spine.
40. By the end of the year, however, he had refused several times to attend healthcare. On 30 December, he was seen by a mental health nurse and a psychiatrist in his cell. Following this meeting, his medication was changed, with the olanzapine stopped and the quetiapine increased.

2010

41. In the New Year, healthcare staff became concerned that the man might have been “palming” his medication (concealing it in his hand when pretending to put it in his mouth). On 19 January, he was taken off Orlistat, a weight loss medication (it is not clear from the records when he was first given Orlistat). His weight was recorded as 159kg.

42. The man was transferred to HMP Norwich on 1 February. His medication was reviewed, and he was put back on Orlistat, as well as being prescribed bezafibrate (which helps lower cholesterol), quetiapine, tramadol, diazepam and busiprone. No mental health concerns were noted at the initial medical health screen.
43. A few days later, he saw the prison GP for a routine appointment. The GP diagnosed that the main issues were low back pain and personality disorder. His pain relief medication was changed from tramadol to dihydrocodeine.
44. He suffered a further asthma attack on 22 February. He was given a steroid inhaler in addition to the salbutamol inhaler.
45. He was transferred to HMP Lowdham Grange on 12 March 2010. It is not clear whether he was given a healthscreen on reception as the first medical records start on 2 April (at the time, Lowdham Grange was not using an electronic medical record). However, he did sign a medication agreement on the day he arrived. This agreement included the clause that he would not “save up or hoard medication”.
46. A mental health assessment planned for 8 April was cancelled after there were not enough available officers on the wing, and he had not been unlocked. He then refused to attend the next appointment, on 12 April, saying he had not slept. Another appointment, for 23 April, was missed although it is not clear why this was.
47. On 10 May, he saw a doctor (it is not clear from the record who this was) and was referred to a dermatologist as he had a problem with the skin on his hand (the doctor thought he might have lichenification, or thickening of the skin).
48. Four days later, the man saw an RMN (Registered Mental Nurse). (Again, it is not clear from the record who this was) During this appointment, he said that his counselling was going well, and that he thought he could talk to the counsellor about things he had previously had difficulty with. It was decided that he should continue with counselling, but only see an RMN with respect to the issue of medication.
49. It appears from the medical records that he slipped on 20 May, injuring his back. A note on 26 May (again, the author is unknown) states that “he has lower pain in his back that is keeping him awake at night”, and that the pain killers he was on were insufficient. The next day, he was prescribed nefopam, a pain killer. It is not clear from the record whether this was given to him to keep in his possession or not. By 8 June, the pain had not decreased. He was prescribed magnesium salicylate (MST, an anti-inflammatory painkiller).

50. An ACCT was opened on 16 August after he was found unresponsive in his cell. He had left a suicide note. During the emergency response, staff gave him naloxone (a drug that is used to treat opiate overdoses). He was taken to hospital and was admitted overnight. Healthcare staff spoke to his parents and told his father what had happened and where he was.
51. When he returned to the prison the next day, an ACCT case review was held. At the review, he said that he wanted to die and did not want to be resuscitated again. He also said that he had explained to his son that he was going to die. He said he had taken MDMA (methylenedioxymethamphetamine, commonly known as ecstasy). While he said he was happy to engage with the mental health in reach team, the meeting (which included the healthcare manager, a safer custody Prison Custody Officer (PCO), a senior manager and another PCO) felt that he needed the support of constant observations (he remained on constant observations until 23 August). The ACCT remained open until he died and a total of 36 case reviews were held.
52. At a review on 18 August, the man said that he was hearing voices and that he still intended to die (in the ACCT ongoing record, it was noted that he told a doctor that “this [that he would kill himself] will happen again”). He remained on constant observations. An urgent mental health inreach referral was made by the Clinical Lead for Healthcare, who had been present at the ACCT review.
53. At another review on 19 August, attended by seven members of staff in addition to him, he said that he had pain in his arm and leg, which he thought might have been caused by an infection. He also said that he had no canteen (prisoners have a spend account which they can use to purchase certain items, known as “canteen”). The Operational manager agreed to look into this for him. Following the ACCT review, a member of healthcare (it is not clear who) went to see him in his cell. He was given further pain relief. He said that he still had little appetite and requested cup-a-soups, baguettes and yoghurts. The member of staff told him that a referral had been made to the inreach team, and they also spoke to the Disability Liaison Officer about moving him to a disability cell. He said that he was feeling more positive and had arranged a visit from his parents.
54. On 20 August, at another review, the man said he had attempted suicide several times before. He said again that he wished no one had found him, and that he was still in extreme pain with his arm and leg. He remained on constant observations. After the review, he was seen by healthcare staff and given antibiotics.
55. The next ACCT review was held on 23 August. He said that he was feeling better, and that he had been visited by his parents. However, he felt low because he had minimal contact with them, and said that he was still hearing voices and he wanted to kill himself. He also said that he was struggling to come to terms with his prison sentence. He remained in pain, despite the antibiotics.

56. At the next review two days later, the review team discussed his sentence. He said that he would not engage with prisoner programmes as he did not think that he should be in prison. The review team explained that they were there to keep him alive, and they discussed whether he would be moved to another unit in the prison.
57. On 26 August, the man was seen in his cell by a practitioner from the secondary mental health team. He told him that he had a personality disorder and had heard voices from a young age. He first saw a psychiatrist at the age of seven. He reported that his current medication usually worked, but not all the time. Although he had a history of a “racist lifestyle” he said he was now a Buddhist and was finding it difficult to reconcile his faith with his desire to kill himself. He continued to feel low in mood, was not sleeping enough and had poor appetite. He had suicidal thoughts “most of the time” but didn’t have a plan, saying “when it happens it happens”. The assessment was cut short as he was in too much pain (from his arm) to continue, and the practitioner arranged a medication review for 2 September.
58. Although the next ACCT review was scheduled for 29 August, it was in fact held on 31 August. At this review, he said that staff had been very good to him. He said he had no suicidal thoughts. At this meeting, it was decided to reduce the level of observations to every 30 minutes (to be done at irregular intervals), with eight decent conversations a day.
59. The practitioner saw the man again on 1 September. They discussed some issues around physical health, including making appointments for an optician and a physiotherapist. He remained in a low mood, and discussed various issues about his home life. They met again the next day. An appointment was made for him to see a consultant psychiatrist for the next day (this was subsequently cancelled and rearranged for 16 September). He told the practitioner that he could kill himself at any time and had the means (razor blades) to do it. He informed the prison staff of this threat. The same day, he was given antibiotics in order to treat some boils on his groin.
60. An ACCT review was held on 6 September. However, the man declined to attend as he had just finished a difficult telephone call with his family. He said that he did not have any suicidal thoughts but was down and depressed. He was waiting to see the doctor to change his anti-depressants, and said that he was receiving good support from staff and another prisoner.
61. He and the practitioner met again on 8 September. He presented as being brighter in mood and said his physical health was slowly getting better. They discussed his sentence (he said he had no regrets about his actions as the people he injured were “intent on killing him”) and agreed that his medication should be reviewed.

62. At the next two ACCT reviews, the man reaffirmed that he was still low in mood but staff were supporting him well. However, he was still experiencing suicidal thoughts.
63. On 16 September, he was seen by a consultant psychiatrist. After taking an extensive history, including a history of hearing voices and insomnia, the psychiatrist increased his quetiapine to 200mg in the morning and 550mg at night. He also arranged to see him again in three weeks, and noted that he thought that he presented an “acute or chronic worsening of psychotic or pseudopsychotic symptoms”. While the psychiatrist did not think that he was at immediate risk of suicide, he did think that this was a “chronic [ongoing] risk”.
64. Ten days later, on 26 September, a nurse was called to the man’s cell. He found him lying on his side on a mattress on the floor. The nurse helped him get up to sit on the bed. During an assessment, he noticed that his eyes were “pinpoint” and his speech was slightly slurred, although he denied taking any illicit substances
65. At an ACCT review on 28 September, he told the meeting about his difficulties with his probation officers. He was not sleeping but was trying to keep in touch with his family. In his medical record, a member of the mental health in reach team noted that he had spoken about his future plans, including his family visits, his birthday and starting work again. She noted that he had a good relationship with his son and that this was a “protective factor”.
66. The practitioner went to see him, to wish him a happy birthday. He noted in the medical record that he had seen his counsellor earlier that day.
67. On 5 October, another review was held. The man attended, but he had only just woken up and said he was tired as he was not sleeping well. However, he also had a job as a cleaner, which he was pleased about. He was generally positive, and said he had no thoughts of self harm. The level of observations was reduced to once per hour, with five conversations a day.
68. The next day, the practitioner visited him in his cell. He was disoriented to the time, thinking it was later than it was and that he had had his dinner. He told the practitioner that he sometimes felt confused and found it difficult to concentrate. The practitioner pointed out that he was due to see the psychiatrist the next day, when they could discuss his medication. In the event, because of a temporary lockdown on the wing, this appointment was rescheduled for 14 October.
69. The man did not attend the next two ACCT review meetings, on 12 and 18 October, as he was tired, although he reported feeling better. As a result, on 18 October, observations and conversations were reduced to three per day.

70. In the meantime, he saw the psychiatrist and the practitioner again on 14 October. He said that he still heard voices and, although the increased dose of quetiapine had helped, his suicidal thoughts came in “cycles” and would inevitably build up again. He said that his back injury was preventing him from going to the gym, which might otherwise help with his sleep pattern. The psychiatrist did not change his medication.
71. On 20 October, the man’s counsellor went to see him in his cell. He said that he was “in a funk” he could not get out of and was feeling depressed. A case review was held, and it was decided to increase the number of observations to hourly, with four conversations a day. The next day, the practitioner saw him in his cell. He told him that he thought he was seeing too many people from mental health. The practitioner agreed to see him less frequently.
72. The man did not attend the next ACCT review, on 27 October, but did say that he was “not feeling right and [didn’t] want to be here”. He said that he did not think that the level of observations were right for how he was feeling, and the review meeting decided to increase them to four observations per hour with four quality conversations. Earlier that day, he had seen a prison GP who had prescribed quetiapine, diazepam, MST (a painkiller containing morphine sulphate) and sertraline (an anti-depressant).
73. The next day, he did attend an ACCT review meeting. He said that he didn’t think staff were talking to him enough. A PCO said that this was because they did not want to wake him up. He accepted this. He told the meeting that he had a razor blade in his cell to use “as and when” and that he continued to feel unsafe and confused. The PCO arranged for all items that he could harm himself with to be removed from the cell. The meeting agreed to observations every 30 minutes, but to increase the conversations to six per day.
74. The practitioner saw him again on 3 November. He found him to be more alert and optimistic, and open to undertaking some sentence planning work as long as it was not in groups. He also said that he was now getting some exercise in the yard.
75. At the next meeting, which was on 5 November, the man said that the change to his medication was making him feel “fuzzy” and not very motivated. He declined to attend the meeting. He reported that he had some thoughts of suicide or self harm, but they were not as strong as they had been before.
76. The next ACCT review meeting took place on 10 November. Although he again did not attend, the review team felt that his intent to end his life was low, and that he would tell staff if this changed. Observations were reduced to one every two hours, although the conversations remained the same (six per day). The practitioner noted in the medical record that he was being supported by several different people, including the mental health team, his counsellor and staff on the wing.

77. Five days later, the PCO chaired the next review. The man had good eye contact, said he was sleeping better and was looking forward to a visit from his family. The PCO mentioned closing the ACCT, but he said immediately that if he could get off the wing he would get some drugs and take an overdose. He said he would tell staff if he felt this way again. The level of observations remained the same, as they did following the next review on 18 November.
78. On the same day, he saw the psychiatrist again. In his notes, the psychiatrist recorded that he thought he presented with chronic borderline personality disorder or post traumatic stress disorder (both personality disorders which can affect mood) rather than a psychotic mental illness. They discussed problems he was having with the Buddhist chaplain (who was from a different Buddhist tradition) and agreed to help find an acceptable Buddhist teacher. He increased the level of sertraline (an antidepressant). At a meeting with the practitioner and a nurse that day, the psychiatrist agreed that sentence planning courses should be suspended for six months, until his emotional state had stabilised.
79. On 24 November, staff conducted a cell search after intelligence suggested that the man had some drugs secreted there. He was required to strip, and, after doing so, threw some tissue in the toilet, saying that he had diarrhoea. Staff retrieved the tissue and found a number of tablets. He was taken to the RIU (the reintegration unit, which was formerly called the segregation unit).
80. The practitioner went to see him before an ACCT review meeting the next day (he was by this time back in his cell). He noted in the medical record that he had secreted six MST tablets, two sertraline and one quetiapine. He said that, at adjudication, the charges against him had been dropped as he had told the hearing of his intention was not to hoard the tablets for a future self harm attempt, but to help him sleep or in case he had any problems getting medication. The practitioner recorded that he was brighter in mood. At the review, the level of conversations was reduced to five per day. However, concealment of drugs was not recorded on the ACCT review.
81. On 4 December, a nurse visited his cell to give him some medication. She had a conversation with him, and he said that he had four people he wished to make peace with. She noted that he looked and sounded down. In her minute on the medical record, she noted that he should be observed taking his medication, and he should not be allowed to take his medication over his sink. She also informed discipline staff, who noted her concerns on the ongoing ACCT record.
82. At the next review, on 8 December, the man was noted to be positive. No mention was made on the ACCT review of the nurse's conversation. It was noted that staff should consider closing the ACCT after one more review. Later that day, another nurse noted on the medical record that "officers have

suspicious that he may be buying/receiving another inmate's tramadol ... tablets – officers to keep an eye and also arrange a cell spin [search] to remove any medications as he could be storing them”.

83. The next day, the man asked healthcare staff whether he could have a TENS machine (transcutaneous electrical nerve stimulation, a machine which uses electricity to aid pain relief). This was provided for him the following day.
84. A review on 16 December found he still positive. He said that he still had thoughts of suicide in his head, placing them at seven on a scale of one-ten. The ACCT was not closed, although observations were reduced to two during the day and two at night, with two conversations a day. He was reported as being down at the next meeting, on 22 December, as a family member was in hospital. Observations were again changed, with two per hour with two quality conversations every four hours.
85. On 31 December, the practitioner saw him again. He was still feeling tired, and was low in mood because of his family member's illness and concerns about his son. However, he noted that he had not expressed any suicidal thoughts.

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86. On 4 January, a DCO made a note in the ACCT ongoing record. The man had requested more toilet roll, which he needed because of the medication he was on. The DCO arranged this for him, and he thanked him. Later that day, the DCO recorded that he had collected his milk (which he needed for his diet) and had done some light cleaning on the wing.
87. Before the next ACCT review, on 6 January, the man's behaviour deteriorated. On 5 January, he had thrown a meal down the wing and had asked to be locked up following this incident. However, he said that he did not have any thoughts of suicide. He did not attend the review, and did not want to engage with staff. On the evening of 6 January, a DCO took him some milk, and he apologised for his behaviour.
88. Early on 7 January, the man spoke to a PCO about his dietary requirements and some missing clothing. He told the PCO that he found it difficult to ask for help. Later that day, staff searched his cell and found that he had been storing medication. He confirmed that he was storing it in order to take an overdose. During the search, he became difficult and was taken to the RIU. An ACCT review was held and observations were raised to six per hour, with eight conversations a day.
89. A safer custody check was made on the man's ACCT document by the Safer Custody Officer, also on 7 January. Staff were reminded that they should record evidence of the required level of conversations on the document, and that they should note the date and time, and sign, their

entries. Managers were reminded of the requirement for them to make checks on the ACCT document.

90. The next day, he had a long conversation with a member of staff on the wing (the signature on the ACCT record is not legible). He had concerns over his back pain, and also said that, the night before, he had had suicidal thoughts. His shoe laces were removed and he was given flip flops. He confirmed that he was happy about this. He was given his milk and, later, his dinner, which was noted to be a special dietary meal. On 9 January, he was given a meal containing eggs, which he refused. He did, however, take more milk and three yoghurts. An ACCT review was held the next day after he had been moved to Houseblock 2. He agreed to work with staff on the wing.
91. The man's personal officer (a personal officer should be a prisoner's first port of call if they have any concerns) saw him on 12 January. They discussed his dietary needs and the possibility of getting a "little job" on the wing. Later that day, he saw his counsellor and told her that he was still feeling suicidal, but "that would never change". He told her that his orthopaedic mattress and some other property had still not arrived from his previous wing. That evening, he spoke to a PCO, as his milk had not arrived.
92. The next morning, the man spoke to his personal officer as, again, his milk had not arrived. She called the kitchen to make sure it was delivered. At an ACCT review that afternoon, he mentioned the lack of milk and that he needed more toilet roll. On 14 January, his personal officer again had to ask for his milk to be delivered. Two days later, he asked a PCO for another toilet roll and a toilet brush. This was arranged that afternoon.
93. On 20 January, he told a PCO that he was intent on ending his life as he thought he shouldn't be in prison. He also said that four people had offered to sell him drugs, but he did not think that they were strong enough, so he had decided to wait until stronger drugs were available. The practitioner also saw him that day, and he told him that he felt "worthless" and "no good". At an ACCT review that afternoon, observations were set as four per hour, with six conversations.
94. Following the ACCT review, the man's personal officer went to check on him in his cell at 10.45pm. However, she could not see him breathing. She called another PCO and, after they got no response from banging on the door and shouting, they went into his cell. He then responded and told them all was well.
95. On 23 January, he reported that his milk was missing. A PCO got some from the kitchen. The next day, he asked another PCO to chase both his mattress (which had still not arrived on the wing) and for some milk.
96. A PCO had a long conversation with him during the night on 26 January. They talked about his low mood and he said that he was looking forward to

discussing his issues with his counsellor the following day. He also asked about some photographs that had not arrived following his cell move earlier that month.

97. The man saw his counsellor on 26 January. She noted that he was low in mood, and that he complained that staff were not making enough checks on him and were “putting temptation in his way”. Later that night, a PCO had another long conversation with him. He explained that the only way to get away from all the bad thoughts and feelings was to kill himself. The PCO noted that he held good eye contact and positive body language. He thanked the PCO and also expressed his thanks to his personal officer and counsellor.
98. On 27 January, the man was taken to reception to collect some property. Later that day, the psychiatrist saw him in his cell. The psychiatrist reported that “he did not seem distressed at all” during the interview, but that he was still concerned about his food, milk, mattress and lack of toilet roll. However, he did say that he felt that prison had “imprisoned his mind as well as his body”. They discussed mental health options, including the therapeutic community at HMP Grendon (he had been there before and did want to go back – a therapeutic community takes a psycho-dynamic group therapy approach to problem solving) and Rampton Hospital (Rampton is a secure hospital). He had concerns about Rampton on the basis of a friend’s experience.
99. On the evening of 27 January, the man spoke to a PCO. He said that he was concerned that he might be sectioned under the Mental Health Act and be sent to Rampton (a Secure Mental Hospital).
100. At an ACCT review of 28 January, he said that he was still having mental health issues. He was, however, being supported by a group of fellow prisoners on the wing, and issues about milk and medication had been resolved. He told staff that he had found a razor blade in his cell and “was very close to using it” but had not done so. Observations were changed to hourly, with eight conversations per day. That evening, he was given more toilet roll and some milk found for him as none had arrived from the kitchen.
101. A PCO completed a week of night duties on 31 January. She checked him at 7.30pm, and he asked her to come and have a chat later. She went to see him at 1.00am. They discussed the previous ACCT review and he was upset that some information had been disclosed to his offender manager. He also told her that he had been offered drugs on the wing, but had heard that they were not very good. She informed the security department of this conversation.
102. That afternoon, the man refused his lunch after being given a non-cholesterol-free option. He refused an alternative. His personal officer spoke to him that afternoon and he said that he was still having problems with the kitchen. He also said that he was feeling paranoid.

103. Another safer custody check on the ACCT document was undertaken by a PCO on 1 February. Staff were reminded to make sure that the prescribed number of conversations were recorded in the ACCT document, and that staff signed and printed their names after each entry. They were also reminded that they should accurately document handovers, especially when he attended an activity. Managers were reminded about the need to check the document.
104. On 2 February, the man spoke to the Safer Custody Officer. He was concerned about how he could facilitate a visit from his brother, and they also spoke about the contact she had with his parents. (At interview, she explained that she had spoken to his parents, with his permission, after each ACCT review to let them know the outcome. They sent a thank you card to her for the support staff had given him.) They also discussed the possibility of him being sent to hospital. She advised him to speak to the mental health nurse.
105. The man did not want to attend the next ACCT review, on 4 February. However, he did speak to the practitioner and gave him a blade, as “that was how he was feeling last night”. He said that , although he felt supported by staff, he did not think that they were always engaging with him. He mentioned that he was not happy with his mattress and was told to put a general complaint in. On 7 February, his personal officer spoke to him, who said that he felt he could only talk to her and another PCO. He also said that the nurse had brought his medication late the night before, and this had made him drowsy through the day.
106. His personal officer saw him again on 9 February. She agreed to try and locate his orthopaedic mattress, which had still not arrived. His counsellor also saw him that day, and found him to be tearful. He told her that he was actively looking for drugs on the wing to take his life with. The next day, he spoke to his personal officer and again said that his night time medication was delivered late, which was becoming an increasing problem. She said she would speak to healthcare. He also complained again about his food, saying he was “living off pitta breads”. She said she would talk to a Senior Manager.
107. On 11 February, the man again was happy to talk to the practitioner, but did not want to attend a meeting. He said that he did not have any current ideas about suicide, but the thoughts were always there. He had been seen engaging with staff and prisoners, but said that he didn’t think that staff were always checking him. He was assured that they were. He told the practitioner that he was “emotionally sore” following a conversation with a family member, and he identified further concerns about the inconsistent delivery of special dietary items and sufficient toilet roll. Later that afternoon, he again complained about the meal he had been given, part of which had been fried.
108. A nurse gave him his medication later that evening. He told her again that he had had enough of life and “in his mind knows he would never be

released from prison". He later spoke to a PCO, and said that he did not think that day staff checked him properly. He also mentioned the problems he was having with food and said that he did not come out of his cell often because he was paranoid.

109. His personal officer next spoke to him on 16 February. He was missing some items of clothing, following the cell search of 7 January, and she helped him order some replacements.
110. The man failed to attend the next review, on 18 February. Observations remained at the same level, hourly with six conversations per hour. The following day, he spoke to his personal officer and said that he felt depressed. He also said that he preferred public sector prisons as "I like to be left alone and in HMP [public sector prisons] I get that". Later that day, his personal officer saw him and they had a disagreement about the arrangements for a family visit. She and another PCO went to see him following this altercation to calm him down.
111. His personal officer spoke to him on 21 February, and he said was going to cancel the family visit because of all the problems it was causing. She offered to try and sort out the problems. He also said that he thought that going to Rampton might be the best thing for him. She said that she would tell the practitioner. On both the next two days, his special meal did not arrive at the servery. On the evening of 23 February, he was sent an omelette, which he could not eat because of the egg content.
112. The man attended his visit with family members on 24 February. He later told his personal officer that he was glad he had booked the visit and had sorted some things out. That evening, the kitchen once more sent the wrong meal, which was exchanged for him by a PCO.
113. The next review was held on 25 February. He engaged well, but was still having thoughts of suicide. He had had a visit from his brother and son and became emotional when talking about it. He was pleased, however, that his mattress had arrived. Later that day, a prison GP increased the dose of MST to help with his back pain, and advised him to discuss an increase to his sedation medication (diazepam) with the psychiatrist.
114. Shortly after the meeting, his personal officer spoke to him in his cell. She noted this conversation in the ACCT document and said that he had made peace with his brother but that his son was very clingy at the end of the visit. He said he was at "stage 10". She asked him what that meant, and he said stage 10 was "ending it". When interviewed by the investigator, she said that she thought that the stages meant that he had "certain things he wanted to do, people he wished to speak to". She also said that he was "quite open" that he would kill himself.
115. She spoke with him again on 2 March. He said that he had got in touch with a cousin and told her that he wanted his cousin to visit "one last time before he goes". He said that he felt that he "was just a shell" and that he was

more determined than ever to take his life. He said that, when the time came, he would speak to his family to tell them goodbye, but that he wanted to stop the “heartache” he was causing them. He told her that he had made peace with his brother and cousin, and only had one more person to make peace with. She felt that once he had done this, he would take his own life. He added that he hoped that certain staff would not be on duty when he to his own life, as he did not want them to find him. She made a detailed entry in the ACCT document to make sure staff monitored him closely as “he had not been engaging well over the past couple of days.”

116. Later that evening, a PCO spoke to the man, who told him that “when he [the man] is ready to kill himself, he shall be doing [so] and nothing will be able to stop him.” During the night, at 4.00am, a PCO found him awake when conducting a routine check. He asked if he was alright, and he told him that he couldn’t sleep “for all the things in my head”. They had a general conversation. The PCO later observed that he was asleep.
117. Operations Manager reviewed the ACCT document later that afternoon. He decided, after speak to the counsellor and safer custody, to reduce the level of observations to four per hour as his mood was “fluctuating up and down”.
118. The counsellor spoke with the man shortly afterwards, and he said again that he would take his life once he had spoken to the last person on his list (or when he found it would not be possible to speak to them). He said he would be making enquiries about getting drugs that would be “good enough” and thought he might wedge his door to make it difficult for staff to get in. He thanked her for the work she had done, and also told her that, apart from the food, the prison had treated him well. She mentioned the possibility of him going to Rampton and she encouraged him to get more information about this.
119. The Safer Custody Officer made another safer custody check on 4 March, reminding staff again about how entries should be made in the ACCT document. The man did not attend the review meeting later that day. However, it was recorded on the ACCT form that he told staff that “he was just waiting to sort one more thing out before he was finished”. Observations remained at four per hour, with six conversations. That evening, he reported further problems with milk and butter, which had not arrived from the kitchen. A PCO resolved this for him.
120. On 8 March, he spoke to his offender supervisor. He said that he felt very low, and isolated, but did not have a plan to kill himself (although he added that he had not had a plan in place when he previously tried to kill himself either). He said that he was not storing any medication as he had previously done. She spoke to an Operations Manager, who spoke to Safer Custody staff. They agreed to maintain the level of observations. His personal officer informed him of this shortly afterwards and recorded that he was “more alert and talkative today than over the past couple of days”.

121. Two days later, the practitioner and psychiatrist saw him again. He said that he had feelings of rejection from the discipline staff, as he thought they only spoke to him because it was their job. The psychiatrist challenged this, saying that staff had tried to reduce observations but had kept on increasing them because of his behaviour. They discussed offending behaviour programmes and he appeared more open to group work than before. The psychiatrist increased the dosage of sertraline, but did not agree to his request to increase the dose of diazepam.
122. The final ACCT case review took place on 11 March. The man did not attend, but did speak beforehand. He said that there were some issues still outstanding which had been raised before. He also mentioned a conversation with the psychiatrist, who suggested some work he could do as part of his care plan. He seemed to perceive these comments as negative. The meeting also agreed to ask the psychiatrist to clarify the position about a possible referral to Rampton. Later that day, the Operations Manager noted in the ACCT document that staff should be making more frequent entries. This message was repeated the next day by the Senior Residential Manager and on 13 March by the Operations Manager.
123. Between 12 and 14 March, the man did not engage with staff to any great extent, often telling them that he wanted to be “left alone” (there are frequent entries in the ACCT document using these words). On 14 March, he was given a letter from a prisoner at HMP Norwich by his Offender Supervisor, but told her that he did not know him so he wouldn’t be writing back. He said that he did not want to talk to anyone. She asked if he knew how to contact her if he needed anything and he confirmed that he did.
124. The last conversation recorded with the man was at 7.00pm on 14 March, with a PCO. He had remained in his cell throughout the afternoon, and had not wanted to talk. However, the PCO recorded that “he said good night to me as I went round at 19.00”.
125. There is, however, a record of a telephone call made by the man at 9.14pm that evening. (At Lowdham Grange, prisoners have access to PIN telephones in their cells, which they can use to call numbers which have been authorised by the prison.) The transcript of the call suggests that he spoke to his father about an injury he had previously suffered. He then spoke to his son. They discussed a mutual acquaintance and he asked his son to give him the acquaintance’s prison number and the name of the prison. He finished the call by saying he would try and call soon, and “don’t forget I love you”.

Events of leading up to the man’s death

126. That night, checks were made and recorded in the ongoing record by a PCO at 10.00pm and 11.50pm, when he was noted to be watching television, and at 1.30am, 3.00am, 4.30am, when he was noted to be asleep. The PCO noted that the man had been seen moving during the

check at 4.30am. (The ACCT log shows that regular observations were made at 15 minute intervals by the PCO throughout the night.)

127. At 6.00am, another PCO took over. He noted in the ongoing record that the man was lying on his bed watching television. At interview with the investigator, the PCO confirmed that the man had looked at him both at 6.00am and during a check at 6.45am. The PCO was aware that he had taken an overdose in the past, and told the investigator that “not one time was I concerned ... nothing was out of character of what I have seen before”.
128. PCO A conducted the next routine check, at 7.00am. She had started her shift at 6.40am. With PCO B, she unlocked prisoners for their breakfast at 7.15am. She checked on the man and found him lying on the floor, on his back. She told the investigator at interview that this was not unusual, as “he suffered quite bad with his back and often if he couldn’t get comfy he’d lie on the floor due to it being cold”. The two PCOs locked the wing up at 7.55am, before unlocking those prisoners who were going to work at about 8.15am. They then did their normal roll check (when they physically count the number of prisoners on the wing). She told the investigator that, at the next check, she saw him still on the floor, but breathing and snoring. She also saw his chest going up and down.
129. Shortly before the 9.00am check, PCO A told PCO B that she had to go off the wing with another prisoner. She told PCO B that the man was lying on the floor, which was not uncommon. PCO B did the check at 9.00am, shouting at him twice through the door hatch and hearing a noise in response. He had his back to the door.
130. At around 9.15am, PCO B returned to the cell. This time, when she shouted to him, she did not get a response. She became concerned, and asked PCO C, who was standing at a cell a few doors down, if he would go into the cell with her.
131. PCO C told the investigator that he was on the wing as he was conducting drugs tests. He said that he went into the cell and touched the man on the arm, which felt “unusually cold”. He then looked into his eyes and told PCO B that something was not right. They tried to clear a space in the cell, but then noticed something coming from the man’s mouth. As they were not sure if it was blood or vomit, PCO B called an emergency using her radio, using the call “code red”, which denotes an emergency involving blood loss. (The control log records states that this was at 9.21am. All times quoted subsequently are from that log.) The officer who was in charge of Houseblock 2, arrived shortly afterwards in response to the call.
132. However, while trying to clear an airway, the three members of staff realised that it was vomit and not blood. PCO C asked PCO B to change the call to a “code blue”, called at 9.22am and indicating an emergency involving breathing difficulties. PCO B and the officer in charge tried to clear the man’s airways, and both PCOs looked for signs of breathing or a pulse. As

they could not find any signs, they tried to get him on to his back so that they could begin cardiopulmonary resuscitation (CPR, a method of maintaining blood circulation when someone stops breathing. Both PCOs confirmed at interview that they have been trained in CPR and that their training was up to date.) However, they first had to remove a telephone cord that had become wrapped around his legs.

133. Nurse A was the first response nurse that day, meaning that she would be the first member of healthcare to respond to an emergency call. She was in the segregation unit issuing medications when the “code red” call came through. She took an emergency response bag, which she had with her, and went immediately to the cell. While she was on the way there, the call changed to “code blue”. She turned to look at the healthcare centre but saw another nurse leaving and decided to let him or another nurse bring the equipment needed for a “code blue” emergency.
134. When she arrived at the cell, the nurse found both PCOs and the officer in charge still trying to obtain a response from the man. At interview, she said that while she took the resuscitation mask from her bag, the other staff rolled him on to his back. She asked other staff, who were at the cell door to call an ambulance, and also asked someone to go to healthcare to fetch some Narcan (a commercial brand of naxolone, use to treat opiate overdoses). At this point, another nurse arrived and staff began to give chest compressions. The nurse took the largest Guedal airway she had (a Guedal airway is used to help maintain a patient’s airway) and inserted it to help the resuscitation attempt.
135. A PCO who had arrived shortly after Nurse A was asked to collect a defibrillator from “the bubble” (a defibrillator is a machine which will deliver an electric shock to the heart when it detects electrical output). However, the defibrillator advised that a shock should not be delivered but that CPR should continue.
136. Meanwhile the Clinical Lead for Healthcare was in a meeting when the emergency was called. As she did not carry a radio, she was alerted by a PCO in healthcare. Just before she arrived on the wing, she was called to say that Narcan was needed, so she collected some and went to the wing. Two doses were injected by a nurse but had no effect.
137. When staff from healthcare arrived, PCO C left the cell. However, when the call for an ambulance was made by Nurse A, Communication staff asked to speak to someone. The PCO went to the office on the wing (known as “the bubble”) and spoke to them to confirm the request for an ambulance. In the control log, it is noted that the call for the ambulance was made at 9.23am. However, the control room needed more details, which is why they asked to speak to someone. The ambulance was called at 9.26am.
138. In the cell, staff rotated in giving CPR. At interview, a nurse said that she oversaw the CPR attempt, ensuring that those giving compressions in

particular were given regular breaks. Nurse A said she tried the defibrillator again, but was advised not to administer a shock.

139. Paramedics arrived at the prison at 9.41am. At this point, another nurse moved to the back of the cell and found a suicide note under a bottle of milk. Nurse A recalled that the paramedics administered some adrenalin (another drug used to treat cardiac arrests). In his clinical review, the reviewer noted that the paramedics tried to administer this through a vein, but were unable to do so. Instead, they administered the adrenalin through a tube in the man's throat. However, they could not resuscitate him and, at 10.16am, pronounced that he had died.
140. The man had named his family as his next of kin. They were informed of his death at their home by two family liaison officers from Lowdham Grange at 4.10pm.
141. Following the man's death a hot debrief was held for staff. (The purpose of a hot debrief to address any immediate issues and to ensure staff are supported.) All staff interviewed by the investigator said that they were happy with the level of support offered following the death. All prisoners on Houseblock 2 were informed individually of the death and offered support if they needed it.
142. A post mortem examination was conducted on 15 March. The pathologist requested a toxicology report. The report found levels of MST and quetiapine that could have been fatal. The pathologist concluded that the cause of death was morphine, quetiapine and diazepam toxicity.

ISSUES

Clinical care

143. A clinical review into the care given to the man while he was at Lowdham Grange was completed by a clinical reviewer. He concluded that he could not find any significant shortcomings in how the man's care was managed at Lowdham Grange. In his opinion, the standard of care was comparable to that which he would have received in the community.
144. The clinical reviewer made specific mention of the mental health care provision for the man. He noted that:
- “The support offered and interventions made by the mental health nurses and psychiatrists was substantial. The Mental Health team did not fail with making any reviews that they had planned. Risk of suicide was always considered and plans made to reduce both this threat and improve his quality of life and progression through the prison system.”
145. We concur with this assessment. It is clear from the man's medical record that there was consistent input from the practitioner and prison doctor, as well as from his counsellor. At the end of every meeting, there was a clear plan for potential action. This input also translated into contributions to his wider care in the prison, which will be discussed later in this section.
146. However, the clinical reviewer raised two areas of concern. The first is the process for administering medication at night. When interviewed by the investigator, a nurse described the process:
- “We knock on the window ... and then the prisoner comes to the flap. We put the tablets under the door in a bag and then they pick up the tablets. Then they have to come with a drink and then they take their tablets in front of us and then before we leave we make sure they've swallowed the tablets and they have to show us, open their mouth, to make sure they've taken the tablets.”
147. However, the nurse then set out the difficulties in this process. She said that it wasn't easy to see the prisoners, sometimes because they have painted their lights, or because they bend down when taking the tablets. She confirmed that she couldn't be sure that tablets had been taken, and she also said that prisoners often complained that they had not been given the right amounts. She said that she would report any incidents when she thought a prisoner had not taken their tablets properly, but that she did not have any specific problems with the man.
148. Another nurse told the investigator at interview that she did not think the current system for dispensing drugs at night was satisfactory. She did, however, recognise that this was a difficult problem as some prisoners could regurgitate medication after appearing to have swallowed it.

149. It is not clear how the man collected enough medication to ensure that he had enough to overdose. However, it is clear that staff who administer drugs at night are aware that this does present such an opportunity. While accepting that it will unlikely that any system will be able to completely solve this problem, we agree with the clinical reviewer that every effort should be made to limit opportunities for drugs to be hoarded in this way. We make the following recommendation:

The Director and Head of Healthcare should ensure that a full risk assessment of the procedures for issuing medication at night is undertaken, with specific reference made to the issuing of medication to vulnerable individuals.

150. The investigator also interviewed the Clinical lead for the Healthcare Department at Lowdham Grange. While talking more generally about the issue of medication, he asked whether she was aware that the man had been found with a supply of drugs during a cell search on 7 January. She confirmed that she was not aware, but that she would expect to be made aware in such circumstances. We agree, and believe that there must be a robust method for the Head of Healthcare to be told when medication is discovered in a cell.

The Director and Head of Healthcare should ensure that there is a robust system for sharing information between all relevant staff about finds of medication during cell searches.

151. The clinical reviewer makes a further point about medication. While it is unclear how the man came to have the medication he used to take his life, he questions whether it was appropriate to give him pain relief medication in tablet form, or whether liquid medication would have been more appropriate. In particular, given his history of accumulating drugs, this would have made it more difficult for him to secrete medication. While accepting that this would make administering the medication at night more difficult than the present system, we make the following recommendation:

The Head of Healthcare should ensure that doctors are aware of all prisoners who have secreted medication (or where there are concerns that they might) and that they consider whether liquid medication would be more appropriate in these circumstances.

152. The clinical reviewer has not recorded any concerns about the emergency response once the man was found in his cell on 15 March. Having reviewed the documentation, and interviewed several of the staff who responded that morning, we also do not have any concerns and believe that staff did everything they could to revive him.

153. The man's family have told us that he had complained that there were difficulties with his medication, either that he was prescribed the wrong medication or being given the wrong dosage. His medication was changed several times in order to find the right drugs in the right dose for him, but we

have found no indication that his concerns were ignored. The clinical reviewer has noted that “[the man] had taken numerous medication combinations and the prescription prescribed at death had been stable for some months and was well tolerated.”

Availability of drugs at Lowdham Grange

154. The man made several references to being able to get drugs on the wing. On 18 November 2010, he told an ACCT meeting that if the ACCT was closed, he would get some drugs and take an overdose. On 20 January 2011, he told a PCO that he had been offered drugs on the wing but that they were not strong enough, and he repeated this to another PCO during their conversation on 31 January. Nurse A, on 8 December 2010, also noted that officers were concerned that he might have bought another prisoner’s tramadol.
155. The availability of illegal drugs is clearly an issue in many prisons. It is worth noting the findings of the HMIP survey during their last inspection, which was conducted on 16 February 2011. In this survey, 18% of prisoners said that they thought illegal drugs were easy to get at Lowdham Grange which, depressingly, compares well with similar prisons. However, in this investigation, it has become clear that the man did not envisage having any difficulty getting hold of drugs, and was more concerned about the quality of drugs that were available.
156. We cannot be sure exactly what drugs the man took as part of his overdose and whether any of these had been procured from other prisoners. It is also clear that staff responded on at least two occasions to intelligence about him having medication or drugs in his cell, and organised cell searches. We do not offer, or expect, an easy resolution to the problem of drugs in prisons. Nevertheless, we make the following recommendation to highlight the issue and to ensure that further action to reduce illegal drugs at Lowdham Grange remains a high priority:

The Director should ensure that all processes to combat the availability of illegal drugs at Lowdham Grange are reviewed, and particular note is taken of the locations in which the man suggested he could obtain illegal drugs.

Addressing the man’s concerns

157. After the man was relocated from Houseblock 3 to Houseblock 2 (via the RIU) following the cell search of 7 January 2011, he raised several issues to staff on a consistent basis. These included the availability of toilet rolls, that his orthopaedic mattress did not follow him after the move, and complaints that provision in response to his dietary needs was poor.
158. Because of the medication he was taking, he required a greater number of toilet rolls than normal. These were provided when he asked, but given that

this was a common request, it is surprising that a more proactive system was not put in place for him.

159. He arrived on Houseblock 3 on 10 January. However, despite frequent requests, his orthopaedic mattress did not arrive from Houseblock 2 until late in February, some six weeks later. While this was not a planned move, it is difficult to see why this took so long to arrange.
160. The most frequent complaint, however, concerned the man's dietary needs. He frequently rejected food because it was not suitable for his diet, and there was also seemingly a problem with milk being delivered consistently to the wing. When staff were alerted to the problem, the issue was normally resolved quickly. However, the fact that issues with both food and milk kept recurring suggests that the problem was not resolved on a systemic basis.
161. What makes this even more concerning is that the man was seen to be a high risk of self harm. While, seen in isolation, these might be seen as being relatively small issues, when taken together, and in a context of self harm, they could assume greater significance. He had made it clear that he intended to take his life at some point, and it is unlikely that these issues had any bearing on the timing of his eventual overdose. However, in another set of circumstances, the resolution of seemingly small issues might be vital in keeping someone safe. We therefore make the following recommendation:

The Director should ensure that, when a prisoner on an ACCT repeatedly raises concerns about his treatment, action is taken and recorded to ensure expeditious resolution of the issues.

162. The specific issue about the provision of special diets, however, needs also to be examined in isolation. It is clear from reading the man's prison record, and especially the ongoing ACCT record, that the continuing failure of the kitchens to provide him with food that met his dietary needs was an ongoing source of frustration. While noting that the Inspectorate found that provision of such meals was generally good, it seems clear that, in this case, it was not. We make the following recommendation:

The Director should ensure that special diets are provided consistently when required, and that a system is introduced so that continued failure to provide a prisoner with a special diet is reported and investigated by an appropriate level of management.

The ACCT process

163. The man was made subject to the ACCT process following an attempted overdose in August 2010. Over the next eight months, staff held 36 reviews, and made thousands of entries in the ongoing ACCT record. Most of these reviews and entries were of good, or high, quality and we are pleased to note that they remained so over a long period of time.

164. In particular, there was regular input from the mental health team into the ACCT review process. Indeed, given that he often chose not to attend the reviews, the practitioner's discussions with him often gave the reviews a crucial insight into his state of mind. We are pleased to note that inspectors found that, more generally, multi-disciplinary attendance and mental health input into the ACCT process was good.
165. However, concerns remain about part of the process. The man himself said he thought that most staff did not really want to talk to him, and only did so because they had to. He pointed out that there were certain staff that this did not apply to. It might not be a coincidence that the most comprehensive minutes in the ongoing ACCT record were made by these officers. There were also several observations made that not enough conversations were being recorded in the ongoing ACCT record (for example, during audits by a PCO on 7 January and 2 February).
166. It is difficult to tell whether other members of staff did have detailed conversations with him. However, it is clear that, if they did, they did not record them in sufficient detail in the ACCT record. While the issue was noted several times, it is not clear what, if anything, was done to remedy it. We make the following recommendations:
- The Director should ensure that all staff are aware of the requirement to record detailed conversations in the ongoing ACCT record and that repeated failures to comply with ACCT monitoring result in appropriate action.**
167. It was also difficult to make out the signatures on several of the entries in the ongoing record. It is important that it is clear who has made an entry in an important document such as an ACCT. As such, we make the following recommendation:
- The Director should ensure staff clearly identify themselves when making entries in ACCT documents.**
168. Of greater concern, however, was that on several occasions detail contained in the medical record did not appear in the ACCT review summary. While this might sometimes be appropriate, for example when the information was strictly medical, at other times clearly pertinent information was not recorded. The most glaring example of this was the review of 25 November 2010. The practitioner noted in the medical record that the man had been taken to the RIU after drugs had been found on him during a cell search. However, the note of the ACCT review meeting that took place that afternoon (which the practitioner attended) does not mention this at all. This information is not medical and is clearly relevant, and should have been recorded. The practitioner's record of ACCT reviews, which he made in the medical record, were often much more comprehensive than those made in the summary of the ACCT review itself. Given that this is the only document that many of the staff will have access to, it is imperative that

all relevant information is recorded accurately. We make the following recommendation:

The Director should ensure that case managers record all relevant information, such as removal to the Reintegration Unit or the secretion of drugs, in ACCT documents

CONCLUSION

169. The man had already made two attempts to take his life before coming into prison in 2008. Within months of arriving at Lowdham Grange, he took an overdose. Following this, he remained adamant that he would succeed in taking his life, and was open with staff about this.
170. An ACCT was opened following the overdose, and remained open until the man's death. Given the length of time it was opened, the process was, on the whole, well managed. However, some important events were not recorded and it is clear that some staff were more engaged than others.
171. The man frequently complained about the provision made to meet his dietary needs. Although these issues were usually resolved by staff the same day, there were repeated failings in the system which meant that the problems were never fully resolved. It also took several weeks for staff to arrange for his orthopaedic mattress to follow him from his previous location.
172. Overall, it is clear that the man intended to kill himself at some point. It is not clear how he managed to gather sufficient medication to take an overdose, although the investigation has exposed the problem of illicit drugs at Lowdham Grange and notes that staff have raised concerns about the process for issuing medication at night and problems in ensuring that prisoners actually consume their medication.

RECOMMENDATIONS

1. The Director and Head of Healthcare should ensure that a full risk assessment of the procedures for issuing medication at night is undertaken, with specific reference made to the issuing of medication to vulnerable individuals.

The Director and Head of Healthcare accept this recommendation but note that clarity should be sought in relation to the term “vulnerable”. The Director agrees to the following:

- *A risk assessment is undertaken in respect of prisoners who are known to be at risk, known to trade or hoard medication, who share cells with individuals and who are at risk and/or trade medication*
 - *In possession medication has been fully reviewed and has reduced by approximately 75% from March 2011 to March 2012*
 - *That a further review of greater reduction potential is carried out to ensure that the absolute minimum numbers of prisoners with in possession medication is achieved*
 - *That clear discussions and decisions are made in consultation with our Healthcare doctors, in relation to a late triage service which fully replaces the issuing of night medication (as is the case in other like prisons)*
 - *That clear consideration and decision making is made in relation to in cell medication safes with the potential for biometric and timed issuing*
2. The Director and Head of Healthcare should ensure that there is a robust system for sharing information between all relevant staff about finds of medication during cell searches.

The response was:

This recommendation is accepted and the Director has agreed to the following:

- *That reported SIR information is routinely (daily report) communicated to Healthcare management*
 - *That the daily report sheet (which has been in operation for over 6 months) clearly captures the medication finds and confirms the action in terms of accountability and responsibility (who is responsible)*
 - *A new form will be created in order to record medication found in possession. This will be reported to Healthcare and placed on System1 as a task to be reviewed by the GP services*
 - *A more coordinated approach to coordinating Security and Healthcare issues will be achieved through inter-operability between Healthcare and Security.*
 - *Substance Misuse/Drug Strategy meetings will have a key contribution from the Security Department and the Security Committee Meeting will have a key contribution from the Healthcare Department*
3. The Head of Healthcare should ensure that doctors are aware of all prisoners who have secreted medication (or where there are concerns that they might) and that they consider whether liquid medication would be more appropriate in these circumstances.

The response was:

This recommendation is accepted and will use the same methods used in recommendation two in terms of reporting medication found in possession and raising tasks on Systm1

4. The Director should ensure that all processes to combat the availability of illegal drugs at Lowdham Grange are reviewed, and particular note is taken of the locations in which the man suggested he could obtain illegal drugs.

The response was:

This recommendation is accepted. The Director notes that:

The Substance Misuse strategy is a “live document” which is subject to a thorough, robust and quality enhancing review process with key contributions from the Security Department, the Residential Directorate and the Reducing Re-offending Directorate. This is a rolling cycle and the 2012 update is due for completion in early summer 2012

5. The Director should ensure that, when a prisoner on an ACCT repeatedly raises concerns about his treatment, action is taken and recorded to ensure expeditious resolution of the issues.

The response was:

This recommendation is accepted and there is a wider acceptance that issues which are “obvious” and require resolution are actually actioned. The resolution and improvements which have already been delivered in order to improve resolution to daily issues include the following:

- *Operation Boost which involved enhanced staffing levels on the residential units at key and high impact times*
- *Zonal Action agenda which promotes a high profile Senior Manager presence throughout the prison on a rolling, rota and routine basis with clear management and leadership challenge and a culture of pro-social modelling which supports staff in their prisoner facing roles and addresses any blockages to delivery*
- *Comments in observations books are of a high quality and are actioned*
- *Eyes Wide Open campaign which encourages the challenging of complacency and the addressing of issues at the earliest opportunity*
- *Increased focus on applications and complaints to ensure that adequate responses are given which address the core of the issue*
- *The Management By Walking About (which underpins the Eyes Wide Open and Zonal Action agendas) ensures that challenge and change is achieved.*

6. The Director should ensure that special diets are provided consistently when required, and that a system is introduced so that continued failure to provide a prisoner with a special diet is reported and investigated by an appropriate level of management.

The response was:

This recommendation is partially accepted. There is a joint responsibility between staff and prisoners in terms of ensuring special diets are consistently delivered and indeed consumed. The Director commits to the following:

- *Good levels of staff and management presence and support in the servery areas of the Residential Units at key times with particular focus on the lunch and evening meals*
- *The encouragement of the use of the prisoners comments book in each of the serveries and the use of notices to raise awareness and direction of usage*
- *Quality checks on menu boards to ensure that prisoners are routinely collecting and consuming the meals issued to them*
- *Increased presence of catering staff as a result of the Operation Boost in order to address dietary queries first hand.*

7. The Director should ensure that all staff are aware of the requirement to record detailed conversations in the ongoing ACCT record and that repeated failures to comply with ACCT monitoring result in appropriate action.

The response was:

The recommendation is accepted in principle but notes that this should be worded to read “The Director should ensure that all staff are reminded of the requirement...”

The reminding of the staff is achieved through the following commitment from the Director:

- *Continual improvement of the Personal Officer Scheme*
- *Continual improvement in the use of the P-Nomis facility (launched in January 2012)*
- *Enhanced staffing at key times in key areas through Operation Boost*
- *Increased quality checking and contributions through the Zonal Action agenda.*

8. The Director should ensure staff clearly identify themselves when making entries in ACCT documents.

The response was:

The recommendation is accepted in principle but should be redrafted to read “The Director should ensure that all staff are reminded to clearly identify themselves...” in ACCT documentation entries.

The Director commits to achieving this through the following:

- *Robust management checks (routine and enhanced as a result of the Zonal Action agenda)*
- *Implementation of the Safer Custody Audit recommendations (carried out in March 2012 with a provisional marking of Amber-Green)*

- *Implementation of “introduction to Safer Custody training” programme, enhanced through locked down training sessions on a monthly basis*
9. The Director should ensure that case managers are reminded to record all relevant information, such as removal to the Reintegration Unit or the secretion of drugs, in ACCT documents.

The response was:

This recommendation is accepted in principle but should be redrafted to read "The Director should ensure that all case managers are reminded to record all relevant information..."

The Director commits to achieving this through the introduction of a new pro forma which will list matters which must always be recorded in ACCT documents including removal to RIU or hoarding drugs.