

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ricky Thorne a prisoner at HMP Exeter on 6 August 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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

The office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Ricky Thorne was found hanged in his cell at HMP Exeter on 6 August 2016. He was 52 years old. I offer my condolences to Mr Thorne's family and friends.

Mr Thorne had mental health issues, and was challenging for staff at Exeter who monitored him as at risk of suicide and self-harm. There was little in the days leading to Mr Thorne's death that indicated he was at imminent and high risk of suicide. It would have been very difficult for staff at Exeter to have predicted or prevented his actions.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman

May 2017

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Summary

Events

1. On 18 November 2015, Mr Ricky Thorne was remanded in custody to HMP Exeter. He had a long history of bipolar affective disorder and was under the care of his local mental health team. He had a history of attempted suicide.
2. When he arrived at Exeter, Mr Thorne was violent and aggressive towards staff and was placed in the segregation unit. A psychiatrist at Exeter noted Mr Thorne displayed no psychotic symptoms and attributed his behaviour to anxiety. The doctor prescribed an antidepressant.
3. On 20 November, staff started ACCT suicide and self-harm prevention measures after they found and removed two strips of bedding in Mr Thorne's cell. Mr Thorne said he wanted to hang himself, and had relationship and mental health problems. He was moved to a standard residential wing but refused to talk to staff, participate in the ACCT review process and take his medication.
4. Mr Thorne's behaviour continued to be challenging. He was frequently demanding, abusive and threatening to staff; he refused to follow instructions, frequently rang his cell bell for trivial matters and refused to take his medication. Prison and mental healthcare staff were concerned that Mr Thorne had mental health problems, especially when he started to display signs of paranoia.
5. On 23 November, staff began ACCT complex case enhanced reviews as Mr Thorne's behaviour had not changed. His mental health was assessed in December 2015, and on 4 May 2016 he was transferred to a secure psychiatric hospital.
6. When Mr Thorne returned to prison on 28 June, staff resumed ACCT monitoring based on his low mood and history of suicide attempts. Staff noted that his behaviour had improved following his time in hospital. However, he said his mood was low because he did not want to be at Exeter and his mental health appeared to deteriorate when his court trial date was delayed.
7. At 3.45pm on 6 August, an officer unlocked Mr Thorne's cell and found that he had hanged himself. Officers radioed an emergency code. Prison officers and nurses tried unsuccessfully to resuscitate Mr Thorne until paramedics arrived. The paramedics pronounced that Mr Thorne died at 4.16pm.

Findings

8. Staff appropriately identified Mr Thorne as at risk of suicide and self-harm when they found strips of bedding in his cell soon after he arrived at Exeter in November 2015. He was a challenging prisoner, but was well supported by prison staff, managers and healthcare staff through safety and disciplinary measures, healthcare monitoring and mental health input. Exeter appropriately referred Mr Thorne to a psychiatric hospital, which could better support his needs.
9. Although Mr Thorne had some risk factors for suicide and self-harm, there was little to indicate to prison and healthcare staff that he was at heightened or

imminent risk in the period before his death. It would have been difficult for staff at Exeter to have foreseen or prevented his actions on 6 August.

The Investigation Process

10. The investigator issued notices to staff and prisoners at Exeter informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
11. On 11 August 2016, another investigator visited Exeter and obtained copies of relevant extracts from Mr Thorne's prison and medical records for the original investigator. She interviewed five people. The original investigator interviewed seven members of staff during the investigation.
12. NHS England commissioned a clinical reviewer to review Mr Thorne's clinical care at Exeter.
13. We informed HM Coroner for Exeter of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Thorne's mother and brother, to explain the investigation. She had no specific matters for the investigation to consider.
15. Mr Thorne's family received a copy of the initial report. They raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to them.

Background Information

HMP Exeter

16. HMP Exeter is a local prison holding about 560 men. The prison primarily serves the courts of the South West. Dorset NHS University Foundation Trust provides health services. Healthcare staff are on duty 24 hours a day.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Exeter was in July and August 2013. Inspectors reported a positive culture at the prison. They considered that reception arrangements were generally satisfactory. They said staff paid attention to safety and vulnerability issues and initial identification of risk of self-harm and suicide was very good. Inspectors were concerned that there were shortfalls in ACCT case management procedures, including poor care planning and a lack of multidisciplinary reviews. Substance misuse services were good.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to December 2015, the IMB reported that healthcare resources were inadequate to provide a service equivalent to the community. The IMB noted that incidents of self-harm at the prison remained high and there had been an increase in self-inflicted deaths in 2015. There were concerns that low staff numbers prevented staff from engaging with prisoners in difficulty.

Previous deaths at HMP Exeter

19. Mr Thorne was the tenth prisoner to take his life at Exeter since 2014.

Assessment, Care in Custody and Teamwork

20. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. 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. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a care map to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the care map have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.
21. Prisons have the discretion to manage the most severely disruptive, volatile and difficult to manage prisoners at risk of suicide and self-harm under an enhanced case review process. Enhanced case reviews are designed to allow staff to respond more flexibly and effectively to the prisoner's individual needs to change the prisoner's behaviour and manage their risk.

Key Events

22. Mr Ricky Thorne had a long history of bipolar affective disorder and was under the care of his local community mental health team. He had tried to take his life by hanging himself in 2011 and 2012.

November and December 2015

23. On 18 November 2015, Mr Thorne was remanded to HMP Exeter for rape and possession of a firearm. In reception, Mr Thorne was uncooperative and acted aggressively to staff so staff moved him to the segregation unit. Mr Thorne told the prison GP that he took venlafaxine (an antidepressant) and cannabis.
24. Mr Thorne refused to engage with staff in the segregation unit. Staff reported he acted strangely and believed that Mr Thorne had mental health issues. A psychiatrist assessed Mr Thorne and noted that he displayed no psychotic symptoms. The doctor attributed Mr Thorne's behaviour to anxiety and that he had not taken venlafaxine for several days. He subsequently prescribed the antidepressant.
25. Shortly before midnight on 20 November, staff removed two strips of bedding they found in Mr Thorne's cell. Mr Thorne said he wanted to hang himself, had relationship and mental health problems and refused to take his medication. Staff began ACCT suicide and self-harm monitoring for Mr Thorne and set the frequency of his observations at five an hour. A Listener (a prisoner trained by Samaritans to offer support to prisoners) spoke to Mr Thorne. Staff noted that Mr Thorne appeared settled afterwards, but was demanding and repeatedly rang his emergency cell bell to ask for cups of tea.
26. The next day, staff moved Mr Thorne to A wing. Mr Thorne's behaviour did not improve. He frequently pressed his cell bell for a range of minor items and refused to follow staff instructions. Mental health staff noted that Mr Thorne's behaviour remained a concern - he spoke rapidly and frenziedly, was demanding and refused to take his medication. Mr Thorne told staff that he needed cannabis, not venlafaxine. He refused to participate in his ACCT reviews, was aggressive and threatened to hurt staff if they did not give him tobacco.
27. On 23 November, staff began ACCT complex case enhanced reviews for Mr Thorne. Five multi-disciplinary enhanced case reviews, chaired by a duty governor, took place between 23 November and 30 November.
28. A Supervising Officer (SO) and a mental health nurse reviewed Mr Thorne in his cell. The SO noted that Mr Thorne was initially cooperative, but soon became agitated and called staff in the mental health team imposters. As Mr Thorne was still refusing medication, the healthcare team arranged to have Mr Thorne assessed under the Mental Health Act 1983.
29. On 26 November, Mr Thorne damaged property in his cell and threatened staff. He was relocated to the segregation unit. The psychiatrist assessed Mr Thorne as displaying signs of paranoia. She told staff to encourage Mr Thorne to take his medication. Staff continued to monitor Mr Thorne under ACCT procedures.

30. The next day, staff reported Mr Thorne's mood was much improved and he engaged well. He continued to refuse his medication. Staff moved Mr Thorne back to A wing on 28 November. Staff continued to monitor him under ACCT procedures, but stopped the enhanced complex case reviews as his mood and behaviour had improved.
31. At the ACCT review on 30 November, the review panel noted that Mr Thorne engaged well, was polite and in good spirits. Mr Thorne said he had no thoughts of suicide or self-harm and had never self-harmed. The review panel reduced his ACCT observations to four times a day (between 10.00pm and 6.00am) with staff required to have two conversations with Mr Thorne each day. The next day, staff stopped ACCT monitoring as they believed Mr Thorne did not present a risk of suicide and self-harm.
32. From 2 December onwards, staff reported that Mr Thorne's behaviour deteriorated. He displayed paranoia, questioned the identity of healthcare staff, refused to take his medication, rang his cell bell repeatedly set fire to tea bags in his cell, claimed his coffee had been drugged, demanded cannabis and displayed threatening behaviour towards staff.
33. On 4 December, Mr Thorne moved to a cell on C wing, used as part of the vulnerable prisoners' wing, at his own request. Staff noted that Mr Thorne was polite but continued to display paranoid behaviour and use his cell bell for trivial matters.
34. On 8 December, a custodial manager in the safer custody team saw Mr Thorne for his post closure ACCT review. A note of the review said that Mr Thorne could not answer a simple question and tended to ramble on to irrelevant subjects. Mr Thorne told staff that he had no thoughts of suicide or self-harm. It said that the mental health team would continue to monitor him.
35. On 16 December, a psychiatrist assessed Mr Thorne to assess whether he was eligible for transfer to a secure psychiatric hospital. The doctor noted that she wanted Mr Thorne to try taking olanzapine, a different mood stabilizer, but he refused.
36. By 30 December, staff noted that Mr Thorne's behaviour had improved. However, Mr Thorne was still refusing to take olanzapine and so the prison psychiatrist suggested a different medication, lamotrigine (for bi-polar disorder).

Early 2016

37. On 4 January 2016, a registrar in psychiatry assessed Mr Thorne. Mr Thorne's behaviour was considered manic, his sleeping pattern was poor and he was overactive. Mr Thorne continued to refuse his medication. The following week, a prison psychiatrist diagnosed Mr Thorne with hypomania and suggested he change his medication change from lamotrogine to depakote valproic acid, a mood stabilizer.
38. On 13 January, Mr Thorne told a mental health nurse that he had stopped taking depakote valproic acid, because it made him feel drowsy. The nurse noted that Mr Thorne appeared to find it difficult to function in a prison setting. On 20 and 26 January, a SO saw Mr Thorne for a mental health review. He noted that Mr

Thorne was agitated and complained about the prison, food, healthcare and legal system.

39. On 27 January, the registrar in psychiatry advised the mental health team that Mr Thorne's psychiatric report had been completed and that he could be admitted to a secure mental health hospital when a bed was available.
40. On 13 February, staff begun ACCT procedures after they received information from Mr Thorne's brother that Mr Thorne intended to harm himself. Staff interviewed Mr Thorne and noted he was withdrawn and very difficult to engage in conversation. He was placed on hourly observations. Mr Thorne refused to participate in the ACCT assessment and told staff he felt suicidal.
41. During the next month, staff described Mr Thorne's behaviour as unchanged. He was paranoid, angry and hostile. The prison psychiatrist diagnosed Mr Thorne with dysphoric mania (a group of bipolar disorder symptoms). He continued to pursue Mr Thorne's admission to hospital but there were no spaces available. Mr Thorne told staff that he had thought about suicide, but had not made any plans. Further ACCT reviews in March and April marked no change to Mr Thorne's behaviour and he still would not take his medication.

4 May 2016

42. On 4 May, Mr Thorne transferred to hospital. While there, doctors diagnosed that he had a cyclothymic disorder (a mild form of bipolar disorder).

Return to HMP Exeter

43. On 28 June, Mr Thorne returned to HMP Exeter from hospital. A nurse and a doctor assessed Mr Thorne in reception. It was noted he was taking olanzapine as a sedative and vitamin B12 injections.
44. An officer interviewed Mr Thorne in the first night centre. He started ACCT procedures based on Mr Thorne's history of attempted suicide, low mood and because Mr Thorne said that he was not happy that he had returned to Exeter. Due to the nature of his offence, he located him on a cell on C wing used as part of the vulnerable prisoners' wing.
45. On 29 June, an officer assessed Mr Thorne under ACCT procedures. Mr Thorne said he did not feel safe at Exeter and was struggling to leave his cell. He was tearful, and said he was not sleeping well, had nightmares, hallucinations and was hearing voices. He talked about his history of attempted suicide. (He had apparently tried to hang himself four or five times before.) Mr Thorne said he had thoughts of suicide. He was worried about the outcome of his impending court hearing. The officer noted that Mr Thorne said he had good family support from his brother, mother and three children. Staff noted that Mr Thorne wanted medication and to see his solicitor.
46. Afterwards, a SO chaired Mr Smith's first ACCT case review with an officer. No one from the healthcare team attended, as they should have done. (The SO noted this oversight during a routine ACCT quality assurance check on 22 July.)

47. A SO noted that Mr Thorne was prescribed medication for his bipolar disorder to stabilize his mood. He discussed the concerns Mr Thorne had raised during his ACCT assessment. The review concluded that Mr Thorne's risk of suicide and self-harm as raised, and noted that the healthcare team should be invited to the next review. He set the frequency for staff to check Mr Thorne as three conversations during the day and hourly observations at night. He scheduled the next ACCT case review for 6 July 2016.
48. The SO noted in Mr Thorne's ACCT caremap that he had three issues to address. Mr Thorne was worried about his safety; he was waiting for his medication to be reviewed; and he was worried about the charges he faced. Staff were aware that Mr Thorne had used the Listener service and they were considering whether they could identify a suitable cellmate for Mr Thorne.
49. On 30 June, a prisoner, who was trained as a violence reduction representative, spoke to Mr Thorne and offered advice about the available support networks.

July 2016

50. On 5 July, ACCT records noted that Mr Thorne told a nurse on the wing that he felt paranoid. A SO spoke to Mr Thorne and said he would arrange for him to spend time on B1 wing during the day, as it facilitated a more open regime than the vulnerable prisoners' wing. A trained Listener spoke to Mr Thorne as part of his induction programme but noted no concerns.
51. Mr Thorne appeared for his court hearing by video link from the prison that morning. The court adjourned and scheduled a trial hearing date for 12 December 2016. Mr Thorne told staff that he felt low in mood and he was not happy about the length of time until the trial date.
52. On 6 July, a SO chaired an ACCT review with a mental health nurse. They noted that Mr Thorne was much more settled since he had returned from hospital. Mr Thorne said he felt let down by the judicial system, the length of time he had been on remand and the trial delay. He said he intended to prove his innocence when the time came. Mr Thorne said he had constant thoughts of suicide but had no plans to take his life and discussed the future. The nurse agreed to review his medication and gave Mr Thorne some in-cell activities to help him occupy his time.
53. They recorded that Mr Thorne's risk of suicide and self harm was high and increased his monitoring to four times during the day, hourly at night, with two conversations daily. The next ACCT review was planned for 12 July. The SO reviewed and updated Mr Thorne's caremap. He added that Mr Thorne had feelings of despair and the nurse would discuss this with staff.
54. The SO and a mental health nurse held an ACCT review on 12 July. Mr Thorne said his mood was low because of the delayed trial date. He had thoughts of suicide. The review panel agreed that Mr Thorne's current location on C1 wing was not helping him to engage in a positive regime and hoped to move him as soon as a space became available. They agreed to discuss Mr Thorne's medication with a doctor. The review panel agreed Mr Thorne's suicide and self-harm risk and observations remained the same.

55. Between 13 July and 29 July, staff held three complex case care meetings about Mr Thorne to discuss his care and management. The group included healthcare and prison staff. Staff considered that Mr Thorne would benefit from a multi-faceted approach to his care. A doctor and a mental health nurse were heavily involved in Mr Thorne's care. The group noted that since Mr Thorne's return from the hospital, he was far more settled and his behaviour had significantly improved. Despite this, his mental health had deteriorated slightly after his trial had been delayed. They agreed that it would be beneficial for Mr Thorne to move to B wing (as soon as a space became available). This would allow him to participate in educational workshops and use his artistic skills, particularly as Mr Thorne was isolating himself on C wing. Mr Thorne told the group that he was still taking olanzapine, but was not happy as it affected his diverticulitis (when the sacs in the intestine lining become infected or inflamed). He said he had no thoughts of suicide or self-harm and talked positively about the future.
56. At the ACCT review on 19 July, Mr Thorne's mood was low but he spoke positively about the future. Mr Thorne said he had no current thoughts of suicide or self-harm. He had contacted his brother but had been unable to speak to his daughter. The review panel lowered Mr Thorne's risk of self-harm level to low, noting that staff should have two conversations with him each morning and afternoon, observe him four times daily and hourly at night.
57. On 25 July, a single cell became available on B wing and staff moved Mr Thorne there. Two SOs conducted an ACCT review. (No one from healthcare attended.) The panel noted that they had arranged for work activities for Mr Thorne to do in his cell. They described Mr Thorne's body language as good noting it was the "best" they had seen him in a long time. Their assessment of his risk of self-harm and the frequency of his observations remained the same.
58. After a complex case team meeting on 27 July, the SO noted that Mr Thorne was well, compliant, taking his medication and appeared to be coming to terms with the wait for his next court appearance.

August 2016

59. On 2 August, a SO (covering for a colleague) and a mental health nurse saw Mr Thorne for an ACCT and mental health review. Mr Thorne told the nurse that his mood was low because he believed he might receive a ten-year prison sentence, which he felt he would not be able to cope with. He had stopped taking his medication and said he was unhappy on B wing as it was noisy. He was also worried about his daughter. Mr Thorne said he had thoughts of suicide and said it would be better for his family and himself. However, he had no current intention to harm himself. He said he had received support from prisoners on his wing who regularly checked on his welfare. The panel did not change Mr Thorne's risk level and staff observations remained the same.
60. On 3 August, a SO saw Mr Thorne for an ACCT review after another prisoner died. Mr Thorne told him that he wished he was the person who had died but said he had no intention to act on his thoughts.
61. A doctor and a mental health nurse saw Mr Thorne on the same day. Mr Thorne told the doctor he had stopped taking his olanzapine as it made him put on

weight. Mr Thorne made no eye contact and said he that although he had thoughts of suicide, he had no active plans. The doctor diagnosed bipolar affective disorder, with a current episode of depression. He prescribed venlafaxine and lamotrigine.

62. On 4 August, two SOs completed an ACCT review. (The mental health nurse contributed to the review by email based on the doctor's assessment of Mr Thorne the previous day). One SO noted that Mr Thorne displayed paranoia, low self-esteem and poor motivation. Mr Thorne said he had some suicidal thoughts. The SO noted that there was no change in Mr Thorne's situation and staff would continue to support him. The mental health nurse's email said that the doctor had prescribed Mr Thorne new medication which would hopefully start to take effect in a few days. They scheduled the next review for 11 August and assessed that Mr Thorne's risk of self harm remained low.
63. Prison medical records noted that Mr Thorne had taken his medication (vitamin B12, venlafaxine and lamotrigine on 5 August and had last taken olanzapine on 29 July.

6 August 2016

64. On the morning of 6 August, staff reported no problems with Mr Thorne. Mr Thorne played cards with prisoners. The prisoners told the investigator that Mr Thorne appeared happy and they had no concerns about him. Another prisoner said he spoke daily to Mr Thorne, and that Mr Thorne had told him about a change of medication. He said he noticed that Mr Thorne appeared to be paranoid, but that on the morning of 6 August, Mr Thorne's mood appeared much better.
65. Staff reported no concerns with Mr Thorne at lunchtime. He collected his lunch and like the other prisoners, was locked in his cell from around midday. At 3.44pm, an officer started the routine unlocking of prisoners on B wing. CCTV footage showed that at 3.45pm, he looked into Mr Thorne's cell. He found him hanged at the back of the cell. He said that Mr Thorne appeared to have attached a ligature (a piece of cord) to a screw about a metre and a half off the ground in a hole near the toilet door handle. His knees were touching the ground.
66. The officer immediately radioed an emergency medical code blue. The control room called an ambulance immediately. He went into the cell and removed the ligature from the wall, supported Mr Thorne's weight, and lowered him to the floor. Staff who were on the landing rushed into the cell and helped him. He assessed Mr Thorne, but found no signs of life. The ligature was removed from around Mr Thorne's neck while he started cardiopulmonary resuscitation by doing chest compressions. Another officer gave Mr Thorne rescue breaths.
67. CCTV footage showed that more staff responded to the emergency call promptly. They removed furniture from the cell to create more space. A nurse arrived at 3.46pm followed by two more nurses who brought the medical emergency bag. The nurse checked Mr Thorne for signs of life but found none. An officer took over chest compressions. The nurse inserted an airway into Mr Thorne's mouth and set up the defibrillator, which found no shockable heart rhythm. They

continued with chest compressions. Another nurse took over compressions from the officer.

68. At 3.55pm, the paramedics arrived but confirmed Mr Thorne's death at 4.16pm.

Support for prisoners and staff

69. Shortly after Mr Thorne's death, a prison manager debriefed the staff involved in the emergency response to offer support and ensure they had the opportunity to discuss any issues arising. The staff care team also offered support.
70. Later that day, staff reviewed prisoners assessed as at risk of suicide and self-harm in case they had been affected by Mr Thorne's death. The prison posted notices informing other prisoners of Mr Thorne's death, and offering support.

Contact with Mr Thorne's family

71. An officer was appointed as the prison's family liaison officer. Mr Thorne's mother, who was his nominated next of kin, lived some distance away so the prison asked a family liaison officer (the deputy governor) from HMP Coldingley to visit her and break the news on their behalf. This was done at 7.30pm. The officer then contacted Mr Thorne's mother to offer support and explain what had happened to Mr Thorne. Exeter paid funeral costs in line with Prison Service policy.

Post-mortem report

72. The post-mortem findings confirmed that Mr Thorne had died from ligature suspension. Toxicology results found no evidence of any illicit substances, but lamotrigine, venlafaxine and olanzapine were detected at expected levels.

Findings

Assessment of risk and management of Mr Thorne's risk of self-harm in custody

73. Prison Service Instruction (PSI) 64/2011 (Safer Custody) and PSI 07/2015 (Early Days in Custody) list a number of risk factors and potential triggers for suicide and self-harm. Mr Thorne had a number of these risks when he arrived at Exeter:
- A history of attempted suicide.
 - Depression.
 - Bipolar disorder
74. Staff appropriately identified these risk factors. Mr Thorne's initial behaviour at Exeter was poor and disruptive. He refused to take his medication and was difficult to manage. Staff decided reasonably and appropriately to escalate his ACCT monitoring to ACCT complex case enhanced reviews to support Mr Thorne's needs better. This initially identified that Mr Thorne's mental health was likely to be better treated in hospital.
75. Until Mr Thorne's transfer to hospital in May 2016, the ACCT remained in force and the mental health team were heavily involved in Mr Thorne's care. Although Mr Thorne's mood was frequently low, he did not try to self-harm or take his life.
76. When Mr Thorne returned to Exeter from hospital in June 2016, staff appropriately began ACCT monitoring based on his history of attempted suicide, mental health problems and his presentation. Staff recognised that Mr Thorne's behaviour had much improved since his previous time at Exeter and he was compliant with his medication. Despite this, Mr Thorne's mood was low and he appeared to struggle with the custody setting. Despite saying that he had thoughts of suicide from time to time, he consistently told staff that he did not intend to act on these thoughts. In July, staff recognised Mr Thorne's mental health had started to deteriorate after news that his trial date was delayed until December 2016. His ACCT risk level and the frequency of his observations were appropriately increased. The healthcare team also held three complex case care meetings to ensure that staff supported and monitored Mr Thorne appropriately.
77. Overall, Mr Thorne received a good standard of care and support under ACCT procedures. There were two occasions (29 June and 27 July 2016) when no one from the healthcare team attended Mr Thorne's case reviews, contrary to PSI 64/2011, which requires ACCT case reviews to be multi-disciplinary. This did not have a detrimental impact on the care Mr Thorne received as the healthcare team (including the mental health team) were fully aware of and continually involved in his care.
78. In the period immediately before his death, Mr Thorne gave little indication that he was at high and imminent risk of suicide and staff could not reasonably have predicted or prevented his actions on 6 August.

Clinical care

79. The clinical reviewer recognised that Mr Thorne was unwell and highly disturbed. Despite this, he concluded that the clinical care Mr Thorne received at Exeter was excellent and equivalent to that he could have expected to receive in the community. He noted that staff understood that the verbal abuse that they received from Mr Thorne was part of his illness, and they treated him appropriately. He noted that staff monitored and recorded effectively Mr Thorne's non-compliance with his medication.
80. The clinical reviewer noted that Mr Thorne's delayed admittance into a psychiatric hospital did not contribute to his death. He said that it was unfortunate that Mr Thorne, a patient who was mentally unwell, had to wait around twenty weeks to be admitted to hospital. He said this put the prison healthcare team under considerable strain, though they appeared to cope well.
81. Mr Thorne's antidepressants were changed on 3 August to venlafaxine. A doctor noted that although there is an increased risk of suicide in the early stages of taking antidepressant treatment, Mr Thorne had only taken one antidepressant capsule the day before he died. He said venlafaxine routinely took at least ten days to have an effect when taken regularly. We do not therefore consider it likely that Mr Thorne's antidepressant contributed to his death.

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