

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Michael Judge a prisoner at HMP Swaleside on 16 March 2017

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

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## 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.

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

Mr Michael Judge was found hanged in his cell at HMP Swaleside on 16 March 2017. He was 31 years old. I offer my condolences to Mr Judge's family and friends.

Mr Judge was a vulnerable man with a history of mental ill-health, self-harm and attempted suicide. We are concerned that Mr Judge's risk of suicide and self-harm was not adequately managed by Swaleside. Suicide and self-harm prevention measures were stopped prematurely, the day before he died, despite indications that Mr Judge's risk had increased. Despite Mr Judge telling staff he had used illicit drugs and overdosed on prescribed medication, nobody fully explored the reasons why or reassessed his risk. It is not the first time that we have made recommendations to address shortcomings in the management of suicide and self-harm prevention procedures at Swaleside, and the Governor must prioritise this area as a matter of urgency.

We have previously criticised Swaleside for a delay in opening the prison gates for the emergency ambulance, and raise this again. While the delay did not affect the outcome for Mr Judge, in another emergency any delay could be critical.

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

**Elizabeth Moody**  
**Acting Prisons and Probation Ombudsman**

**November 2017**

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# Summary

## Events

1. On 18 February 2015, Mr Michael Judge was remanded to custody at HMP Chelmsford and was subsequently sentenced to ten years. Mr Judge had significant self-inflicted injuries when he was first remanded at Chelmsford and was managed under Prison Service suicide and self-harm procedures (ACCT). He was transferred to HMP Swaleside in November 2015.
2. Mr Judge had a history of drug misuse in the community and continued to misuse drugs, including new psychoactive substances (NPS), while in prison. He was diagnosed with personality disorders and had a long history of mental ill-health, frequently had suicidal thoughts and in total was subject to ACCT procedures on eight occasions.
3. Mr Judge became more depressed in the weeks before his death. He disclosed to prison staff, his friends and his mother that he struggled with his sexual identity, he continued to use NPS, which made him paranoid, and he said he had overdosed on prescribed medication and felt suicidal. Staff started ACCT procedures on 14 March, after Mr Judge told a chaplain he wanted to kill himself, but stopped them the following day.
4. On 15 March, after he had been locked in his cell for the night, Mr Judge asked to speak to Listeners. They spent around 45 minutes with him. A night patrol officer last spoke to Mr Judge around midnight; neither he nor the Listeners had any specific concerns about Mr Judge's welfare. At 7.23am, a prison officer found Mr Judge hanged in his cell, with a cord from his shorts tied around his neck, attached to the bed. Staff and paramedics were unable to resuscitate him and, at 8.07am, paramedics recorded Mr Judge had died.

## Findings

5. Mr Judge had a number of factors which increased his risk of suicide, including a long history of mental ill-health, previous suicide attempts and NPS use. We found that Mr Judge's risk of suicide and self-harm was not properly assessed or managed. Staff failed to complete the immediate action plan when ACCT procedures were started on 14 March. The ACCT was closed after the first case review the next day, despite Mr Judge continuing to experience the effects of NPS and disclosing that he had taken an overdose of prescribed medication. Mr Judge's counsellor visited him that afternoon and recorded he had used NPS, but the counsellor did not feel he had the authority to reopen the ACCT as senior and more experienced colleagues had only recently closed it.
6. Closing an ACCT while a prisoner is under the influence of NPS needs careful consideration, including a detailed assessment of risk factors and potential triggers. Prison staff recorded Mr Judge was low in mood, continued to hear voices and was troubled about his sexuality, but concluded his risk had reduced to low. We found no evidence Mr Judge's risk had reduced and in fact, there were indicators present that increased his risk. We consider that the ACCT was closed prematurely.

7. There was no involvement with healthcare staff following Mr Judge's disclosure that he had taken NPS. The duty nurse wrongly believed the counsellor was a trained mental health nurse and had made an assessment during his welfare visit. Mr Judge also disclosed that he had overdosed on prescribed medication, but the reasons were never fully explored by healthcare staff.
8. The dose of Mr Judge's antidepressant (mirtazapine) was increased from 30mg to 45mg daily on 13 January 2017, but was never reviewed to assess efficacy or his compliance. National guidance states those prescribed antidepressants should be reviewed every three months, and reviewed after one month following a dose change. Mr Judge was not reviewed.
9. Although an ambulance was called immediately, there was a delay in getting the ambulance through the prison gate when it arrived at Swaleside. Although this delay did not affect the outcome for Mr Judge, any delay in future cases could be critical.
10. There is no evidence the duty governor debriefed all staff involved in the emergency response.

## Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular:
  - All staff should have adequate ACCT training and refresher training.
  - All staff should take the possible side effects of NPS into account when assessing risk of suicide and self-harm.
  - All staff should be reminded of their responsibility to start (or reopen) suicide and self-harm prevention measures for prisoners at risk and ensure all relevant information is recorded.
  - Staff should set actions on the immediate action plan or caremap that are specific, meaningful and tailored to the individual to reduce their risk.
- The Governor and Head of Healthcare should ensure substance misuse services and the mental health team are effective and provide:
  - Swift access to appropriate support.
  - Guidance for improved communication with mental health team and prison staff about individuals' presentation and needs.
  - All staff are vigilant for signs of use of NPS and are briefed about how to respond when a prisoner appears to be under the influence of such substances.
  - Details of all interventions from substance misuse services are recorded in prisoners' records.

- The Governor should ensure that all prison staff are made aware of and understand the local violence reduction policy and their responsibilities, in particular, he should ensure staff:
  - Are clear about their responsibilities.
  - Support and protect victims.
  - Take appropriate measures against perpetrators to address violent or antisocial behaviour.
- The Governor should ensure that all staff, irrespective of status, position or experience, are provided with formal support from the prison, following a death in custody.

## The Investigation Process

11. The investigator issued notices to staff and prisoners at Swaleside, informing them of the investigation and asking anyone with relevant information to contact her. Two prisoners responded.
12. The investigator visited Swaleside on 22 March and obtained copies of relevant extracts from Mr Judge's prison and medical records.
13. NHS England commissioned a clinical reviewer to review Mr Judge's clinical care at the prison.
14. The investigator and an Assistant Ombudsman interviewed 13 members of staff and four prisoners at Swaleside on 19 and 20 April. Interviews on 20 April were conducted with the clinical reviewer, who also interviewed the prison doctor by telephone. The investigator also interviewed one member of staff and three prisoners at Swaleside on 2 May, and interviewed four members of staff by telephone in June and July.
15. We informed HM Coroner for Mid-Kent and Medway District of the investigation. She gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
16. One of the Ombudsman's family liaison officers contacted Mr Judge's mother to explain the investigation. Mr Judge's mother wanted to know what support Mr Judge received, as he was clearly distressed in the days before he died.
17. Mr Judge's family received a copy of the initial report. They did not highlight any factual inaccuracies within the report.
18. The prison also received a copy of the report and identified no factual inaccuracies.

# Background Information

## HMP Swaleside

19. HMP Swaleside, HMP Elmley and HMP Standford Hill form a group of prisons on the Isle of Sheppey. Swaleside holds life-sentenced prisoners and those serving determinate sentences. The prison houses up to 1,112 men. IC24 Integrated Care provides primary healthcare at Swaleside. Oxleas NHS Foundation Trust provides mental health services. Substance misuse services are provided by RAPt (Rehabilitation of Addicted Prisoners trust).

## HM Inspectorate of Prisons

20. The report of the most recent inspection of Swaleside was in April 2016. The inspectorate said Swaleside had been a struggling prison for some time, and the population had become more challenging. The Inspectorate described the mental health provision as very good. The prison had started to improve ACCT monitoring for prisoners at risk of suicide and self-harm. Illicit alcohol (hooch), diverted medication and new psychoactive substances (NPS) were widely available. The drug strategy committee meetings were not always well attended by key areas, including security.

## Independent Monitoring Board

21. 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 most recently published annual report for the year ending April 2016, the IMB was concerned about the continuing shortage of experienced prison officers at Swaleside. In the Board's view, this was the major reason that the preceding year had been a very difficult one for the prison. The Board said that Swaleside could not be considered to be a safe prison and noted there had been continued bullying by prisoners. Swaleside's Safer Custody team had undergone some radical changes due to restructuring. They had revised processes to ensure that there was a central knowledge of all ACCT cases to enable timely and multi-disciplinary ACCT assessments and reviews.

## Previous deaths at HMP Swaleside

22. Mr Judge was the fourth prisoner to take his life at Swaleside since December 2014. There has been another self-inflicted death since Mr Judge died.
23. After two deaths at Swaleside in 2012, we made recommendations to improve the emergency response procedures. However, we identified a similar issue following a death in August 2016 and again in this case. Swaleside must ensure staff follow national and local guidance.
24. We have also previously made recommendations about improving the management of suicide prevention measures, which we repeat.

## Assessment, Care in Custody and Teamwork

25. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level

of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

26. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular, multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.
27. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Safer Custody*.

### **New Psychoactive Substances (NPS)**

28. New psychoactive substances, previously known as 'legal highs' are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.
29. In July 2015, we published a Learning Lessons Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
30. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and HMPPS continues to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

### **Incentives and Earned Privileges (IEP) Scheme**

31. Each prison has an Incentives and Earned Privileges scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are four levels: entry, basic, standard and enhanced.

## Key Events

32. On 18 February 2015, Mr Michael Judge was remanded to HMP Chelmsford charged with a violent offence against his partner. On 14 July, he was sentenced to ten years imprisonment, with an additional five years on extended licence. He was not due to be released until 17 February 2025. Mr Judge had been to prison before.
33. Mr Judge arrived at Chelmsford with self-inflicted cuts to his neck and wrists. These injuries were inflicted prior to his arrest on 13 February, and Mr Judge was treated in hospital. A community psychiatric nurse assessed him on 17 February, and recorded that Mr Judge had been engaged with mental health services since 2003. Mr Judge had a history of anxiety, depression and suicidal thoughts. He had been sectioned under the Mental Health Act (section 136) and spent some weeks as a voluntary inpatient in a mental health unit after he had attempted to hang himself in December 2014.
34. Mr Judge had withdrawn from alcohol during his time in hospital and was discharged with a clinical diagnosis of adjustment reaction and borderline personality disorder, with dissocial personality traits. (A person with a personality disorder may find coping with demanding situations difficult. They often find it difficult to establish and maintain positive relationships with others. There are different types of personality disorder but generally the person's traits (whether that be their thoughts, feelings or behaviour) are extreme or unusual in some way.)
35. At an initial health screen on 18 February, a mental health nurse recorded that Mr Judge said he had intended to take his own life before his arrest and continued to have thoughts of suicide. Staff started Prison Service suicide and self-harm procedures (known as ACCT) and made a referral for the visiting psychiatrist to assess him. A nurse completed an alcohol and drug assessment and started an alcohol withdrawal care plan. Mr Judge was located in the healthcare inpatients unit.
36. In total, between 18 February 2015 and 16 March 2017, ACCT procedures were put in place on nine separate occasions to support Mr Judge (five during his time at Chelmsford and four while at Swaleside). Mr Judge frequently had thoughts of suicide and told staff and other prisoners he felt hopeless, struggled with his sexual identity and often got into debt as he continued to misuse drugs.
37. The visiting psychiatrist assessed Mr Judge on 24 February. He noted his borderline personality disorders, continued his antidepressant medication (mirtazapine) and advised him of the emotional support available. Mr Judge completed his alcohol detoxification and received support from the substance misuse service. Throughout his time at Chelmsford, Mr Judge engaged with the mental health in-reach team.
38. Mr Judge was transferred to Swaleside on 19 November 2015. The substance misuse team RAPt supported Mr Judge and he completed the Stepping Stones rehabilitation course in November 2016. However, he often became depressed when unable to cope and resorted to misusing drugs and illicit alcohol (hooch).

39. Mr Judge was moved to the basic level of the IEP scheme when he was discovered to have illicit alcohol in his cell and when he refused to go to work. However, at times he also maintained being on the enhanced level of the regime and received very good wing reports about his work and contribution in the kitchen, as a servery worker, and his commitment to the choir. Mr Judge also attended art classes, regularly attended church and played guitar in the prison band.
40. Mr Judge received support from the mental health in-reach team and emotional wellbeing support mentors (EWB - prisoners trained by Oxleas to provide emotional support to other prisoners and supervised by the mental health in-reach team. Staff and prisoners described Mr Judge as a likeable, quiet man, but who was very 'up and down', especially when he had been misusing drugs.
41. There is documented evidence that Mr Judge accrued drug debts and as a result, moved wings on several occasions. Healthcare staff identified that Mr Judge had been stockpiling his medication and, from 13 March 2016, he was not allowed to keep his medication in his possession (ideally prisoners should be responsible for managing their own medication and have the autonomy they would have in the community, unless there are identified risks to security or individuals).
42. Mr Judge lived on G Wing from 4 January, until he was moved to H Wing on 20 August. He attended weekly counselling sessions between late July and September 2016, when he reported that his sleep had improved and he continued to work on accepting himself. (After he failed to attend three appointments, he was discharged from the counselling service on 11 October.) Mr Judge's antidepressant medication was stopped on 30 August, as he had not collected it for some time. A worker from the mental health team assessed Mr Judge on 1 September, when he told her he had no thoughts of suicide and self-harm.
43. On 29 September at 6pm, Mr Judge informed wing staff that he was in £60 debt on H Wing, a debt that had possibly followed him from G Wing. A Supervising Officer (SO) started a violence reduction investigation and submitted a security intelligence report. The alleged perpetrator was not interviewed. The SO said she got permission from Mr Judge and referred him to the violence reduction representatives on the wing (prisoners who offer support or advice in a way that prison staff cannot). Mr Judge told her that he had agreed to repay the debt over several weeks and, on 1 October, the victim support plan was closed, with no further action.
44. On 9 November, another security intelligence report was submitted suggesting Mr Judge may be the victim of bullying as a result of another drug debt. There is no evidence any action was taken specifically to support Mr Judge as part of the violence reduction strategy, but band practice was stopped to reduce prisoner movement between wings.
45. On 1 December, a prison GP assessed Mr Judge, as he reported feeling increasingly anxious and struggling to sleep. Mr Judge declined to be referred to the mental health team, but the GP encouraged him to engage. The GP re-prescribed an antidepressant (mirtazapine). A nurse completed a medication in-

possession risk assessment and Mr Judge was allowed to collect his medication weekly. Mr Judge moved to C Wing on 5 December.

46. On 8 January 2017, Mr Judge was suspected to be under the influence of illicit alcohol, but later admitted to wing staff that he and two other prisoners had smoked NPS. Mr Judge was described as stumbling around and unable to give a coherent response to staff. He was issued with an IEP warning. There is no evidence healthcare staff examined Mr Judge, and he was locked in his cell for his own safety.
47. A psychologist assessed Mr Judge on 12 January. She noted Mr Judge continued to have suicidal thoughts, still struggled to sleep and wanted his medication increased. The next day, a prison GP increased the dose of Mr Judge's antidepressant medication, and prescribed two days of sleeping tablets (zopiclone).
48. The psychologist Mr Judge on 17 January and she discussed his care at a multi-disciplinary meeting the next day. A referral for counselling was made and a worker employed by NHS Oxleas as part of their mental health team started weekly cognitive behavioural therapy (CBT) with Mr Judge between 10 February and 10 March (a talking therapy that can help an individual manage problems by changing the way they think and behave). During the last session Mr Judge was tearful and said it was due to him no longer using NPS. His next appointment was scheduled for 17 March.
49. A friend of Mr Judge told the investigator that around the first week in March Mr Judge said he had accrued a drug (NPS) debt of approximately £40 and wanted to move from C Wing to A Wing. Mr Judge moved to A Wing on 4 March. He also said that Mr Judge had told him he was gay, or at least confused about his sexuality, and on Sunday 12 March appeared 'overwhelmingly depressed' during the chapel service. The chaplain said she was aware that Mr Judge was involved in drug and alcohol abuse while on G Wing, but thought he was more settled on C Wing. She said Mr Judge struggled with guilt around his faith, offence and sexuality and she had also noticed he was 'not his usual self' during the chapel service.

### **Monday 13 March**

50. Mr Judge's art teacher spoke to the chaplain when they were leaving the prison. She was concerned about him as he had been tearful in her class and had to leave early. (His friend also recalled this when we interviewed him.). The chaplain agreed that she would speak to Mr Judge in the morning.
51. All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample. The investigator listened to Mr Judge's calls on 13 March. At around 4.40pm, Mr Judge spoke to his mother for approximately 11 minutes. Mr Judge told his mother he could not cope and was 'not doing very well... I'm so broken'. He became tearful and said he had had a sexual relationship with another boy of the same age when he was younger, but that he had also been abused. Mr Judge told her that he felt worthless because of his offence, was using drugs and that talking about his feelings was not helping. Mr Judge said he had asked, but God could not help

him. He told his mother he loved her and asked about his son, but his credit ran out and the call ended abruptly.

52. Mr Judge was very upset his telephone credit had run out. He spoke with his EWB mentor and a SO allowed him to call his mother again from the wing office. The SO told the investigator Mr Judge said he had not intended to tell his mother he was gay, but that he was distressed and it was difficult to follow what he was saying. She confirmed the EWB mentor was in the room to provide Mr Judge with some support when he called his mother. The mentor told us that Mr Judge was scared about telling his mother he was gay, but that she was supportive and reassuring. The SO said she did not have any specific concerns about Mr Judge's wellbeing when the call ended. She did not put an entry on Mr Judge's prison record as she said she did not have time before her shift finished. Mr Judge did not make any other telephone calls before he died.

### **Tuesday 14 March**

53. The chaplain spoke to Mr Judge in the morning for about 30 minutes in the chapel. He told her he felt very low and wanted to kill himself. Mr Judge said that he was upset after his conversation with his mother and thought that he was being spied on through holes in the walls and ceiling of his cell. She began ACCT procedures at 10.25am. She recorded on the 'concern and keep safe' form, that Mr Judge felt paranoid, believed people were spying on him and felt guilty about the harm he had caused his victim. Mr Judge also disclosed he had told his mother over the telephone that he was gay, and had been abused when he was younger.
54. The chaplain informed the Safer Custody team that she had initiated an ACCT and set hourly observations until Mr Judge's ACCT assessment. The immediate action plan, which should have been completed within one hour by the wing manager, was not done.
55. For the remainder of the day and evening, Mr Judge appeared more settled. He spent most of his time in his cell and did not attend work due to his increased anxiety. Mr Judge slept throughout the night and no concerns were recorded.

### **Wednesday 15 March**

56. The last recorded observation on the ACCT was made at 7.30am, when an officer noted Mr Judge was still asleep. Another officer carried out an ACCT assessment at 10.30am. Mr Judge told her he had been self-medicating with NPS, heard voices and had considered ending his life, but did not currently feel suicidal. Mr Judge also told her that he had taken an overdose of a week's prescribed medication; she did not record when or what medication. She recorded that Mr Judge read his Bible, used rubber bands to inflict pain as a substitute for cutting himself and was in contact with his mother, all of which he found helpful.
57. A SO was assigned as Mr Judge's ACCT case manager and chaired the first ACCT review at 11.00am, with an officer, a member of the mental health team and Mr Judge. He recorded Mr Judge said he heard voices as a result of using NPS, but no longer wanted to self-harm. He recorded that Mr Judge was well

supported by staff on the wing and his EWB mentor. He recorded 'hearing voices' had been identified as a risk, but noted that Mr Judge was 'working to beat them'. He assessed Mr Judge's level of risk as low and closed the ACCT. The member of the mental health team informed Mr Judge he had to collect his medication daily and was no longer allowed to keep it in his possession. A post-closure review was scheduled for 22 March.

58. An officer was on duty on A Wing. When he unlocked Mr Judge's cell after lunch, Mr Judge asked for his door to be shut as he wanted to go back to bed. He told us that he checked Mr Judge was okay, and that Mr Judge did not appear distressed and he closed his door. He saw Mr Judge on the landing later in the afternoon, although was unsure of the time, and had no concerns about his welfare.
59. At 2.30pm, the counsellor recorded in the wing observation book that he had conducted a welfare visit after being told that Mr Judge had been placed on an ACCT as a result of taking an overdose of prescribed medication. He noted that Mr Judge had said he had 'just done a spliff of Spice' and reported hearing voices and people talking to him in his cell. He noted Mr Judge said he had no more NPS in his cell. He also noted that he had informed a wing officer.
60. The counsellor also made an entry on Mr Judge's medical record at 2.47pm. He recorded he had told wing staff and the emergency response nurse that Mr Judge was under the influence of NPS and that he had updated the wing observation book and submitted a security report. He did not record which staff he had informed, although an officer and a nurse confirmed to the investigator that the counsellor had spoken to them. He did not reopen the ACCT and Mr Judge's cell was not searched.
61. A prisoner, who was a Listener and friend of Mr Judge, told the investigator Mr Judge had disclosed to some of his friends in the band that he was gay, but that he struggled with his sexual identity. He said Mr Judge had asked to speak to him in his capacity as a friend and, when he arrived on A Wing that afternoon, a SO told him Mr Judge's ACCT had been closed, which surprised him. He said he got to Mr Judge's cell around 5.10pm, but Mr Judge was talking to another prisoner, who he described as an 'attention seeker' and someone he did not think was a good influence. He did not stay but spoke to another band member, who said Mr Judge appeared low. This prisoner told the investigator that he had removed items from Mr Judge's cell (a razor and broken cutlery) to prevent Mr Judge from hurting himself, but said there was no indication from their conversation that he intended to kill himself.
62. An operational support grade (OSG) started work on A Wing at around 7.20pm. He told the investigator he had not worked on the wing previously that week. He received a handover from the day staff and was responsible for observing two prisoners subject to ACCT procedures, but did not know that Mr Judge had been on an ACCT or that the ACCT had been closed earlier that day. He said he 'would have' checked the wing observation book and seen the entry that Mr Judge was suspected of smoking NPS, but said it would not have raised any specific concern as NPS use was widespread across the prison.

63. Mr Judge pressed his cell bell at 8.40pm. Cell bell records confirm that the OSG responded in less than a minute, and Mr Judge told him that he felt down and he was offered a telephone call to Samaritans, which he declined. Mr Judge asked to speak to a Listener (prisoners trained by Samaritans to support other prisoners) and the OSG said he would organise Listeners to come over to the wing, and told Mr Judge to press his cell bell again if anything changed. He used the wing telephone to contact the night manager, but there was an incident being managed in another part of the prison and he was told there would be a delay. He informed Mr Judge of the delay and went back to his cell twice more to update him and check his wellbeing. He said Mr Judge was sitting quietly on his bed.
64. Two Listeners arrived at Mr Judge's cell some time later (the time is not recorded and there is a discrepancy about the time). There is no closed circuit television (CCTV) on A Wing to verify the timings. They told the investigator it was some time after 8.45pm, although the OSG thought it was about an hour later. Two officers said they escorted the Listeners to A Wing around 10.15pm. The Listeners said they spent around 45 minutes talking to Mr Judge. The cell bell records show Mr Judge's bell was pressed at 10.59pm and reset at 11.00pm, when the OSG said the Listeners asked to return to their own wing.
65. The Listeners told the investigator Mr Judge appeared to be under the influence of NPS, but said nothing about taking his own life and they had no immediate concerns about his welfare. A SO and an officer escorted the Listeners back to their wing. The SO said she asked the Listeners if Mr Judge was okay and if she should arrange for him to be seen by the mental health in-reach team the next day. She said they did not disclose any details of their contact with Mr Judge, but indicated contact with the in-reach team would be advisable.
66. The OSG told the investigator he checked on Mr Judge about 30-40 minutes after the Listeners had left (which would be about 11.30 to 11.40pm), and although Mr Judge said he was still feeling low, he had no specific concerns. This was the last contact he had with him.

#### **Thursday 16 March**

67. An officer arrived on A Wing around 7.15am to start his day shift. The OSG provided a handover to two officers and informed them Mr Judge had seen two Listeners the night before. An officer started a roll check (a count of all prisoners) and when he arrived at Mr Judge's cell he looked through the observation panel and saw him on the floor, but did not immediately see anything unusual (as prisoners are known to sleep on the floor). He tried to obtain a response and when he did not obtain one he radioed a code blue medical emergency.
68. An officer responded and brought the defibrillator with her. A custodial manager, the deputy governor and the Governor, also responded to the emergency code as they were close by. The custodial manager opened the door and went into Mr Judge's cell. Mr Judge had tied a cord from his shorts around his neck, attached to the bed. The custodial manager cut the ligature and started cardiopulmonary resuscitation (CPR). A nurse responded to the code blue. Prison staff had

already attached an automatic defibrillator and they continued CPR until paramedics arrived.

69. According to the control room records made by an officer, the code blue was radioed at 7.23am and an ambulance was requested immediately. South East Coast Ambulance Service records confirm they received a request for an emergency ambulance at 7.24am. Paramedics arrived at Swaleside at 7.36am, but were delayed at the gate. They arrived at Mr Judge's cell at 7.43am but were unable to resuscitate him. At 8.07am, Mr Judge was pronounced dead. Mr Judge did not leave a suicide note.

### **Contact with Mr Judge's family**

70. A family liaison officer, prison chaplain and the Governor broke the news of Mr Judge's death to his next of kin at 12.30pm. Swaleside contributed towards the costs of Mr Judge's funeral, in line with national instructions. Mr Judge's mother said his clothes were returned with blood stains. The family liaison officer said she had spoken to the staff that had prepared Mr Judge's belongings, and was assured his clothes were not stained.

### **Support for prisoners and staff**

71. After Mr Judge's death, the deputy Governor debriefed the prison staff involved in the emergency response. He offered his support and that of the staff care team. Healthcare staff said they felt well supported by their manager, but were not invited to attend the debrief.
72. The prison posted notices informing other prisoners of Mr Judge's death, and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm, in case they had been adversely affected by Mr Judge's death. A well attended memorial service was held on 27 March in the prison chapel.

### **Support for Listeners**

73. The Listeners who visited Mr Judge the night before he died told the investigator they were upset at the length of time it took staff to inform them of Mr Judge's death, and also that they were questioned about their contact with him. They said they had asked to speak to the Listener coordinator, but were asked to complete statements for the police before doing so. They said they felt as though they were being treated as suspects. The Samaritan and Listener coordinator also reflected there had been an issue around the Listeners confidential role and not being fully supported by Swaleside. He reiterated that anything said to the Samaritans or a Listener is confidential under the Samaritans' values and therefore cannot be shared with others, even if there is a risk that someone intends to take their own life. The Head of Safer Custody said he has almost daily contact with Listeners and the Samaritans co-ordinator and neither had raised this as an issue.

### **Post-mortem report**

74. A pathologist concluded that Mr Judge had died from hanging. A toxicology report confirmed there was a slightly raised level of mirtazapine (antidepressant), as well as paracetamol and morphine. Mr Judge had been prescribed

paracetamol and codeine (an opiate) for back and shoulder pain so these results were not unusual and were not at harmful levels.

# Findings

## Assessment and management of risk

75. Prison Service Instruction (PSI) 64/2011 - *Safer Custody*, lists a number of risk factors and potential triggers for suicide and self-harm. Mr Judge had a number of risk factors: history of self-harm and suicide attempts, mental health illness, substance misuse, hopelessness, low self-esteem and serving a sentence for a violent offence against his ex-partner.
76. PSI 64/2011 requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm and take appropriate action. Staff judgement is fundamental to the ACCT system. The system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. While a prisoner's presentation is obviously important and reveals something of their level of risk, it is only one piece of evidence in assessing risk. Staff should make a considered, objective evaluation of all risk factors when assessing the risk of suicide and self-harm.
77. A chaplain began ACCT procedures at 10.25am on 14 March and noted Mr Judge was at a high risk of self-harm and suicide. The wing manager should have completed an immediate action plan within an hour, but this was not done at all. He told the investigator he had not had ACCT refresher training for some years, despite asking for training, but accepted that the failure to complete an action plan was an oversight on his part. Observations, which should have been conducted hourly until the assessment interview, stopped at 7.30am on 15 March, even though the assessment interview was not held until 10.30am, so at least two observations were missed. The ACCT was closed at the first case review held half an hour later.
78. All staff who had contact with Mr Judge during the ACCT assessment or review considered him to be at low risk of suicide and self-harm, despite the presence of a number of risk factors, including being under the influence of NPS, hearing voices, his overdose on prescribed medication and his struggle with his sexual identity. These factors should have caused concern. Instead, staff relied heavily on Mr Judge's protestations that he did not intend to harm himself. The risks and triggers were not properly identified and there is no evidence that Mr Judge's risk had decreased from the previous day.
79. The chaplain who had opened the ACCT the day before, told the investigator she was very angry the ACCT had been closed so quickly, especially as neither she nor her chaplain colleagues, who knew Mr Judge well, were invited to the ACCT review (as they typically would be).
80. The counsellor made a welfare visit to Mr Judge at 2.30pm, and Mr Judge told him he had smoked NPS. He did not reopen the ACCT, but he did inform an officer and a nurse. He did not consider it was his responsibility to reopen the ACCT, despite his concerns for Mr Judge's welfare. He said he had only worked at Swaleside for around four months and because senior staff had attended the ACCT review, and were aware Mr Judge was hearing voices, he did not think it would be appropriate to challenge the decision to close the ACCT. He disclosed

that he had little knowledge of Mr Judge's prison history and in retrospect had naively relied on his presentation.

81. The officer recalled being told by the counsellor that Mr Judge had smoked NPS, but he did not check on his wellbeing, did not search his cell or consider reopening the ACCT. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular:**

- **All staff should have adequate ACCT training and refresher training.**
- **All staff should take the possible side effects of NPS into account when assessing risk of suicide and self-harm.**
- **All staff should be reminded of their responsibility to start (or reopen) suicide and self-harm prevention measures for prisoners at risk and ensure all relevant information is recorded.**
- **Staff should set actions on the immediate action plan or caremap that are specific, meaningful and tailored to the individual to reduce their risk.**

## Clinical Care

82. In January 2016, we published a thematic review of lessons to be learned from our investigations into self-inflicted deaths in prisons, where mental health issues were involved. In the report, we highlighted the need to ensure mental health and substance misuse services work together, to provide a coordinated approach to prisoner care, and that all interventions from substance misuse services should be recorded on the prisoner's medical record.

### *Management of Mr Judge's mental health*

83. Mr Judge disclosed his previous contact with community mental health services and he was referred to the prison mental health team appropriately. The mental health multi-disciplinary team discussed Mr Judge in their meetings, attended by primary and secondary care mental health practitioners, and he received counselling on three separate occasions during his sentence, and was assigned an EWB mentor.
84. On 1 December, Mr Judge was re-prescribed an antidepressant and a nurse completed a medication in-possession risk assessment. She incorrectly recorded there was no known history of medication incidents, despite the fact that Mr Judge had his medication removed on 13 March 2016, as he had been stockpiling. She also recorded Mr Judge was not at risk of self-harm, despite his history, and that there were no issues around bullying, despite him being identified as a potential victim on at least two occasions.
85. NICE (National Institute for Health and Care Excellence) guidelines stipulate that all patients on long term antidepressants should be reviewed every three months, and reviewed typically after four weeks if there is a change in medication or dose.

Mr Judge had his dose of mirtazapine increased from 30mg to 45mg daily on 13 January 2017, but he was never reviewed.

86. On 15 March, Mr Judge disclosed he had overdosed on a week's supply of prescribed medication, but there is no evidence he was examined by healthcare staff. The reasons he overdosed were not fully explored and it was not recorded in his medical record. A SO told the investigator he assessed the risk of further overdose had reduced as Mr Judge no longer had his medication in possession. A drugs worker said she assumed the overdose was mirtazapine and had been taken the previous week, but did not check. Mr Judge should have been reassessed by the mental health team.

### *Substance Misuse Services*

87. Swaleside's healthcare provider, Integrated Care 24 Ltd (IC24), issued guidance for healthcare staff dated February 2017, on the management of prisoners suspected of being under the influence of NPS. This guidance states that during normal hours, healthcare staff should triage prisoners and monitor for any deterioration in their condition. In May 2017, Swaleside issued guidance for all staff and managers on the care and control of prisoners suspected of misusing NPS.
88. Prison staff recorded Mr Judge was suspected to be under the influence of NPS on 8 January 2017, but there is no evidence he was examined by healthcare staff. On 15 March, a nurse recalled being told by the counsellor that Mr Judge said he had smoked NPS, but she did not assess him. She told us that she wrongly believed the counsellor was a mental health nurse and assumed he had assessed Mr Judge himself. She accepted in interview that she should have recorded her discussion with him and decision on the medical record and should have examined Mr Judge.
89. The prison issued a protocol, in May 2017 after Mr Judge died, about how staff should respond when they suspected a prisoner of using NPS. As the prison is already taking steps to address the supply and demand for NPS, we do not make a further recommendation, but stress the need for continuing effort to reduce supply and demand for illicit substances and for all staff to be aware of the risks of the use of NPS, particularly when prisoners are assessed as at risk of suicide and self-harm
90. Those we interviewed generally described communication between the mental health and substance misuse teams as good. However, sharing of information relied on individuals, as there was no central recording system to which staff could refer. A healthcare manager said that the inability of substance misuse services to record their interactions with prisoners on medical records had been a recurring issue in death in custody investigations. She told us that substance misuse workers are to be given access to SystmOne at Swaleside. We very much welcome this.

**The Governor and Head of Healthcare should ensure substance misuse services and the mental health team are effective and provide:**

- **Swift access to appropriate support.**
- **Guidance for improved communication with mental health team and prison staff about individuals' presentation and needs.**
- **All staff are vigilant for signs of use of NPS and are briefed about how to respond when a prisoner appears to be under the influence of such substances.**
- **Details of all interventions from substance misuse services are recorded in prisoners' records.**

### Ambulance delay

91. Swaleside's local protocol is clear that an ambulance should be called immediately, when a medical emergency code is radioed, in line with PSI 3/2013 - *Medical Emergency Response*. An officer correctly used his radio to convey the emergency and an ambulance was called immediately.
92. PSI 03/2013 also contains mandatory instructions that prison staff should prevent unnecessary delay in escorting ambulances and paramedics to the patient. However, the ambulance service recorded that they were delayed entering the prison and it took seven minutes to reach Mr Judge. Although the delay did not affect the outcome for Mr Judge, any delay in future cases could be critical.
93. The duty governor told the investigator that the delay was probably due to the change over from the night to day shift staff and not having enough staff available. He acknowledged that it was the duty governor's role to coordinate an emergency situation, but said that he did not do so on this occasion due to the time of day, lack of staff and the presence of other senior managers. We identified a similar issue when an ambulance was delayed for 10 minutes, after a death in August 2016, similarly due to a lack of available staff. Despite Swaleside accepting our recommendation in that case, nothing appeared to have changed.
94. During the debrief after Mr Judge's death, Swaleside identified there had been a delay in the ambulance getting through the gate. In response, the Governor issued revised guidance in a Notice to Staff (NTS 075.17) on 20 April, reiterating the gate procedures when an emergency code has been radioed. As Swaleside have already issued a reminder to staff, we do not make a recommendation.

### Violence Reduction

95. Guidance on the effective management of violent prisoners is contained in PSI 64/2011. The national instruction states, "Every verbal or physical act of violence must be challenged. Appropriate sanctions for perpetrators must be applied robustly, in a fair and consistent manner. Victims must be supported and protected". Swaleside has a local Violence Reduction Policy, dated September 2016, which sets out the steps staff are required to follow to support victims of violence, abuse or threats, and the actions to be taken to address a perpetrator's behaviour.

96. On 29 September, a violence reduction investigation was started as Mr Judge said he was a victim of bullying as he was in debt. A SO spoke to Mr Judge, but nobody interviewed the alleged perpetrator who was located on a different wing. The SO said the wing manager or safer custody were responsible for doing this. The Head of Safer Custody told the investigator there was no reason why the SO could not have interviewed the alleged perpetrator, although it was not uncommon for staff not to go onto different wings. When the SO closed the investigation, she referred the case to safer custody. The Head accepted that they appeared to have overlooked a review, particularly when there was a further reported incident on 9 November.
97. We consider that Mr Judge did not receive the level of support from staff that he could have expected and make the following recommendation:

**The Governor should ensure that all prison staff are made aware of and understand the local violence reduction policy and in particular, he should ensure staff:**

- **Are clear about their responsibilities.**
- **Support and protect victims.**
- **Take appropriate measures against perpetrators to address violent or antisocial behaviour.**

### **Staff Support**

98. Giving staff the opportunity to collectively discuss an incident and reflect on all aspects of how it was managed is fundamental to providing the prison with feedback on any issues that need to be addressed (or indeed good practice). It also provides those directly involved with an opportunity to process events. There is no evidence the duty governor held a debrief for all staff involved in the emergency response, which is a mandatory requirement set out in PSI 08/2010, *Post Incident Care*, and we make the following recommendation:

**The Governor should ensure that all staff, irrespective of status, position or experience, are provided with formal support from the prison, following a death in custody.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations