

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr John Mayhew a prisoner at HMP Durham on 15 January 2017

**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*

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**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 John Mayhew was found hanged in his cell on 15 January 2017 at HMP Durham. He was 58 years old. I offer my condolences to his family and friends.

Reception staff at HMP Durham did not properly consider Mr Mayhew's risk of suicide and self-harm after he was recalled to prison and staff repeatedly missed opportunities to address his well-documented risks. This resulted in staff ending suicide and self-harm monitoring for Mr Mayhew prematurely. There were deficiencies in the mental health care Mr Mayhew received.

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**

**November 2017**

## Contents

Summary .....	1
The Investigation Process .....	4
Background Information .....	5
Key Events .....	7
Findings.....	12

# Summary

## Events

1. On 17 December, Mr Mayhew was recalled to HMP Durham for breaching his licence conditions. He had a history of attempted suicide and self-harm, alcohol misuse and mental health issues, including bipolar affective disorder.
2. When he arrived at Durham, Mr Mayhew denied thoughts of suicide and self-harm. He did not tell healthcare staff that he had bipolar disorder but said he had tried to kill himself recently and had seriously harmed himself a year earlier. He said that he was anxious and depressed and had recently been in a mental health hospital. Healthcare staff referred him to the mental health team. Reception and healthcare staff did not fully check the details of Mr Mayhew's licence revocation, person escort record or his historic clinical records.
3. Mr Mayhew thought he had been recalled to prison for 28 days but on 19 December, a prison probation officer, from the resettlement team told him he had to stay in prison until November 2019. Mr Mayhew seemed anxious but denied thoughts of suicide and self-harm. Nevertheless, staff started suicide and self-harm monitoring procedures, known as ACCT, and a mental health nurse assessed Mr Mayhew. The nurse concluded that Mr Mayhew did not have an acute mental illness and referred him for cognitive behavioural therapy. The nurse did not look at Mr Mayhew's historic clinical notes, his licence revocation, cell sharing risk assessment or his person escort record and was not aware of his diagnosis of bipolar disorder, his history of suicide attempts and self-harm or his alcohol misuse.
4. ACCT monitoring stopped a few hours later at the first case review. The officer who opened the ACCT document was not invited and did not attend. Staff based their assessment on how Mr Mayhew presented and did not use information in his prison or clinical records to inform their decision.
5. That day, Mr Mayhew missed his doctor's appointment. The doctor and a mental health nurse discussed and stopped Mr Mayhew's prescription for olanzapine (an antipsychotic medication). Neither had reviewed Mr Mayhew's historic clinical notes and they were unaware of his bipolar disorder. The information they received from Mr Mayhew's community GP outlined his prescriptions but not his diagnosis.
6. On 6 January 2017, an officer gave Mr Mayhew his recall papers, which set out the terms of his recall to prison, and Mr Mayhew's prison offender supervisor explained it to him later that day. Neither of them read the detail of the papers and both were unaware that Mr Mayhew had expressed suicidal thoughts and had bipolar disorder. The officers did not start ACCT procedures.
7. On 9 January, the primary care mental health team assessed Mr Mayhew for cognitive behavioural therapy but discharged him after he denied thoughts of suicide and self-harm.
8. During the morning roll check at 4.50am on 15 January, officers found Mr Mayhew hanged in his cell. Staff radioed a code blue emergency and the control

room called an ambulance promptly. Healthcare staff arrived but did not start cardiopulmonary resuscitation as Mr Mayhew had signs of rigor mortis. Paramedics arrived and pronounced Mr Mayhew dead at 5.32am.

## Findings

### Assessing Mr Mayhew's risk

9. Durham did not adequately support Mr Mayhew. They did not fully identify or address his risk factors or assess his level of risk appropriately at reception on 17 December, and they did not properly consider the implications of his recall for his risk of suicide and self harm or support him appropriately when he learned that he had to spend longer in prison than he had anticipated.

### ACCT procedures

10. When staff appropriately if belatedly started ACCT monitoring on 19 December, they failed to access all relevant information about Mr Mayhew's risk. They did not invite the person who raised concerns and started ACCT procedures and they stopped monitoring prematurely. They did not identify any caremap actions to support Mr Mayhew.

### Clinical care

11. The clinical reviewer concluded that the care Mr Mayhew received was not equivalent to that which he would have received in the community. A doctor should have seen Mr Mayhew in reception about his medication and his alcohol and possible illicit drug use were not sufficiently addressed.

### Mental health

12. Mr Mayhew was appropriately referred to the mental health team in reception but the referral was cancelled after the basic mental health assessment which preceded his ACCT review. This should not have happened without a full assessment based on all available information. We are concerned that a doctor and mental health nurse changed Mr Mayhew's antipsychotic medication without checking his historic clinical records.

## Recommendations

- The Governor and Head of Healthcare should ensure that staff consider and share all available information and records about prisoners' risk appropriately, and that the specific risk factors associated with recalled prisoners are properly understood.
- The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national instructions. In particular:
  - Staff should understand the importance of understanding prisoners' risk factors and not rely excessively on their presentation in deciding whether to start ACCT procedures.

- Case managers should receive effective ACCT training and understand their responsibilities to hold case reviews in line with national guidelines.
  - ACCT assessments and reviews should consider and record all available information and known risk factors when determining the level of risk of suicide and self-harm.
  - Staff should create ACCT caremaps with specific, meaningful and time-bound actions, aimed at reducing prisoners' risks to themselves; progress should be considered and updated at each review.
  - Case reviews should include all relevant people involved in a prisoner's care, and in particular, the person who started ACCT procedures should be invited to attend or provide input to the first case review.
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- The Head of Healthcare should ensure that the healthcare team, including the mental health team, complete a full risk assessment for prisoners identified at risk of suicide and self-harm, that decisions when assessing prisoners, considering referrals and reviewing medication are made using all available information, and that reasons for decisions are clearly documented.

## The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Durham informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
14. The investigator visited Durham on 16 January 2017. She obtained copies of relevant extracts from Mr Mayhew's prison and medical records.
15. The investigator interviewed eleven members of staff at Durham on 23 and 24 March.
16. NHS England commissioned a clinical reviewer to review Mr Mayhew's clinical care at the prison. The investigator and clinical reviewer jointly interviewed the healthcare staff.
17. We informed HM Coroner for Durham and South Darlington of the investigation who sent the results of the post-mortem examination. We have given the coroner a copy of this report.
18. One of the Ombudsman's family liaison officers contacted Mr Mayhew's sister and brother, to explain the investigation. They asked how staff treated his bipolar disorder and depression. They asked how Mr Mayhew was monitored under suicide and self-harm prevention procedures, why they were ended and whether staff contacted Mr Mayhew's probation officer.
19. Mr Mayhew's family received a copy of the initial report. They did not make any comments.

## Background Information

### HMP Durham

20. HMP Durham, which holds up to 996 men, is a local prison serving the courts of Durham, Tyneside and Cumbria. Care UK provides primary healthcare services and Tees, Esk and Wear Valley NHS Trust provides mental health services.

### HM Inspectorate of Prisons

21. The most recent inspection of HMP Durham was in October 2016. Inspectors reported that they were not confident that the risks and vulnerabilities of newly arrived prisoners were properly identified and that reception and first night processes were of a poor quality. They said that ACCT assessment had improved since the last inspection and prisoners said that the care they received from staff was good. Inspectors found that while care plans were multi-disciplinary, the post-closure ACCT reports were sometimes late. Inspectors considered that the quality of healthcare for prisoners with mental ill health was much better than they usually see and there was effective care planning for prisoners with severe and enduring mental health issues.

### Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its annual report for the year to October 2016, the IMB reported that healthcare services were disrupted by short staffing and sickness. The IMB said that mental health care continued to be good and that wing staff were trained in mental health awareness. They noted their concerns that the prison was overcrowded and operated close to its operational capacity, with cells built for single occupancy nearly all occupied by two prisoners. The IMB reported that the number of prisoners monitored under suicide and self-harm prevention procedures between 2015 and 2016 had increased significantly, which they suggested was due to good practice and awareness.

### Previous deaths at HMP Durham

23. Mr Mayhew was the second prisoner to take his life at Durham since January 2016. Both investigations identified concerns about ACCT monitoring and mental health services.

### Assessment, Care in Custody and Teamwork (ACCT)

24. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multidisciplinary 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. 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.

# Key Events

## Background

25. In November 2007, Mr John Mayhew was sentenced to 12 years in prison for the attempted murder of his partner. He was released on licence in November 2013, with conditions not to travel to Durham or contact his partner and daughters. During 2016, Mr Mayhew tried to take his life a number of times. He had a history of attempted suicide, self-harm and alcohol misuse. Mr Mayhew had a day release from a mental health hospital on 14 December 2016, with a view to discharge and starting cognitive behavioural therapy in the community. He travelled to Durham, hoping to see his daughters by chance.

## HMP Durham

26. On 17 December 2016, Mr Mayhew was recalled to HMP Durham for breaching his licence conditions. A healthcare support worker and a mental health nurse saw Mr Mayhew for his initial reception health screen that day. They said that it was extremely busy in reception as a large number of prisoners had arrived from another prison, which left them little time to assess prisoners comprehensively.
27. Mr Mayhew told the mental health nurse that he felt anxious and had depression but did not have thoughts of suicide or self-harm. He said that he had tried to kill himself around two weeks earlier when he stepped in front of a moving lorry. He said that he had stabbed himself in the chest/stomach area in early 2016, had been treated in a mental health hospital recently and had taken olanzapine (an antipsychotic medication) and propranolol (anxiety medication) for around 10 years. The reception health screen nurses did not check Mr Mayhew's licence revocation papers, his person escort record or historic clinical records and were unaware of his recent mental ill health, recent suicide attempts or that he had bipolar affective disorder.
28. The mental health nurse referred Mr Mayhew to the mental health team and told the investigator that he thought he should have seen a doctor that day because of his medication. This did not happen because it was late on Saturday and the doctor had finished work at 5pm.
29. The mental health nurse said that he assessed Mr Mayhew based on his appearance and what he told him at the time. He was aware that Mr Mayhew had been recalled but as he was lucid, pleasant, gave good eye contact and denied current thoughts of suicide or self-harm, the nurse and healthcare support worker decided that suicide and self-harm monitoring, known as ACCT, was unnecessary.
30. Mr Mayhew went to F wing, the first night centre, where he was given a single cell because he was assessed as at risk of violence to others. An officer completed Mr Mayhew's induction and told him where to get support if needed. He did not consider that ACCT procedures were necessary.
31. Mr Mayhew tested positive for benzodiazepines (medication with sedative and addictive properties) but denied that he had taken them knowingly.

## 19 December 2016

32. At 10.45am on 19 December, Mr Mayhew saw a probation officer from the resettlement department. Mr Mayhew told her he had recently tried to kill himself (by stepping in front of a lorry) and had commented, “I don’t care if I live or die” and that he had “nothing to live for”. He said he was deliberately not eating and had misused alcohol before he arrived in prison. She looked at Mr Mayhew’s details on the Offender Assessment System (OASys – a risk assessment document) which contained information about his physical and mental health and his recent attempts of suicide and self-harm. She started ACCT procedures because she was concerned about Mr Mayhew’s risk. Staff agreed to monitor him three times a day until his risk was fully assessed.
33. At 11.35am, a clinical practitioner in the drugs team assessed Mr Mayhew, who told her that he did not misuse drugs but took medication for his mental health problems, though he could not remember the name of his medication. Mr Mayhew maintained that he had not knowingly taken benzodiazepines but admitted drinking alcohol most weekends. He denied that he was dependent. The clinical practitioner concluded that Mr Mayhew was not dependent on alcohol, his mood was “okay” and Mr Mayhew declined referral to alcohol and drug misuse services.
34. In the afternoon, a mental health nurse assessed Mr Mayhew’s mental health to inform his forthcoming ACCT assessment (rather than in response to Mr Mayhew’s mental health referral). The nurse said that this assessment also had the effect of dealing with Mr Mayhew’s referral to the mental health team. He said that when he assessed Mr Mayhew ahead of the ACCT assessment, he had no time to access historic information about Mr Mayhew’s risk and based his assessment on how Mr Mayhew presented at the time.
35. The clinical lead for mental health confirmed that it was standard practice to cancel a mental health referral if a prisoner’s mental health was assessed as part of ACCT procedures. She said that while the ACCT assessment should be informed by all available information, this did not always happen, as the duty mental healthcare worker, because of the lack of access to computerised clinical records on the wing.
36. The mental health nurse told the investigator that Mr Mayhew was a little anxious but engaged well when he assessed his mental health. Mr Mayhew denied thoughts of suicide and self-harm and said he planned to return to Durham to re-establish his relationship with his daughters. Mr Mayhew told him that he had recently been seen by mental health services in the community and had been prescribed medication for about 10 years (but could not remember the name of his medication – it was olanzapine). The mental health nurse noted that Mr Mayhew had no signs of acute mental illness and questioned his prescription. He said that Mr Mayhew did not tell him that he had bipolar disorder and he saw no reason for him to take olanzapine. Mr Mayhew agreed to stop taking it and agreed that a doctor should review his medication. The mental health nurse referred Mr Mayhew to the Rethink programme (organised by the primary mental health team) and discharged him from the mental healthcare team’s caseload.

37. An officer assessed Mr Mayhew's risk of suicide and self-harm as part of ACCT procedures. He noted that Mr Mayhew wanted to return to live in the North East and regain contact with his daughters. The officer and the mental health nurse were not aware that this would breach Mr Mayhew's licence conditions, and thought that his plans were positive and a protective factor for his risk of suicide and self-harm. The officer did not look at Mr Mayhew's prison records to obtain further information. During the meeting, Mr Mayhew said that he wanted his medication reviewed.
38. At 3.00pm, a Supervising Officer (SO) chaired the first ACCT case review with Mr Mayhew. The mental health nurse and the officer attended. They agreed to stop ACCT monitoring and did not complete a caremap. The probation officer was not invited to the case review and none of the staff present were aware of Mr Mayhew's history or risks and they had not looked at his licence revocation, person escort record, prison records or his details on OASys. Mr Mayhew told them that his earlier comments to the offender supervisor were not how he felt, that he had everything to live for and did not want to die.
39. That day, Mr Mayhew did not attend his appointment with a prison GP. The GP discussed Mr Mayhew with the mental health nurse, and they agreed that there was no clear reason why Mr Mayhew should have been prescribed olanzapine. Although Durham asked for Mr Mayhew's community clinical records, they only received his prescriptions but no diagnostic information.

## **20 December**

40. On 20 December, Mr Mayhew saw a prison GP, who noted that he was very troubled and his mood seemed very flat. The GP reviewed Mr Mayhew's medication and they agreed that he would stop olanzapine and start fluoxetine, an antidepressant, and continue with his blood pressure medication and propranolol for anxiety. He did not check Mr Mayhew's historic clinical records and remained unaware of his increased risk and diagnosis of bipolar disorder.

## **27 December**

41. On 27 December, an SO completed an ACCT post closure review. He noted that Mr Mayhew had received medication, would speak to prison staff if he needed support and that he had no support from friends and family. Mr Mayhew said that he did not want to work or use the gym and was content to sit in his cell. He wanted to live in the North East on his release. The SO was not aware at the time that this breached his licence conditions.

## **January 2017**

42. On 6 January, (14 working days after Mr Mayhew was recalled to prison), an officer gave Mr Mayhew his recall papers. The front page of the report said, "Mr Mayhew is currently expressing suicidal ideations ...." The officer said that he did not read the document and was unaware of Mr Mayhew's risks. He said that Mr Mayhew accepted the information about his recall and he had no concerns about his risk of suicide or self-harm when he left him.
43. The Head of Safeguarding told the investigator that senior officer offender supervisors from the Offender Management Unit were required to read prisoners'

recall papers and explain the reasons for recall and for how long they would remain in prison when they gave the papers to prisoners. She said that the senior offender supervisor should identify a prisoner's risks from the papers, share the information with the ACCT case manager if the prisoner was subject to ACCT monitoring or start ACCT procedures, if necessary.

44. Later that day, Mr Mayhew's prison offender supervisor visited him to explain the terms of his recall. Although an officer had already told Mr Mayhew that he had been recalled to prison until the end of his sentence, she said that Mr Mayhew believed that he had only been recalled for 28 days. She explained to Mr Mayhew that this was not the case and reiterated that he had to serve his remaining sentence (until 18 November 2019) in prison. The offender supervisor said that Mr Mayhew could appeal the decision but he declined. She said that Mr Mayhew initially seemed anxious about staying in prison, but eventually he appeared calmer and said that he understood. She did not consider ACCT monitoring.
45. On 9 January, a trainee mental health practitioner and a mental health practitioner assessed Mr Mayhew for cognitive behavioural therapy. They noted that Mr Mayhew presented as settled and said his mood had improved since his medication was changed. Mr Mayhew did not discuss the terms of his recall but focussed on his eventual release and being able to move to the Durham area to see his daughters. They were not aware that Mr Mayhew's plans breached his licence conditions and saw them as positive. They took no further action as Mr Mayhew said that his mood was not low or depressed and he denied thoughts of suicide and self-harm. The trainee mental health practitioner said that he had not seen Mr Mayhew's recall papers or any information about his risk.

## 15 January

46. At 4.50am on 15 January, two officers began a routine roll check on F wing. One officer told the investigator that, generally, he opened cell door observation panels during roll checks, turned on the night light and waited to see movement from the prisoner. He arrived at Mr Mayhew's cell door and saw Mr Mayhew hanging, suspended from a belt attached to the bar on the top bunk bed. The officer did not get a response after calling Mr Mayhew so immediately radioed a code blue at 4.55am. (A code blue is a medical emergency call indicating that a prisoner is unconscious or having difficulties breathing which alerts healthcare staff to bring an emergency bag and for the control room staff to call an ambulance immediately.) Control room staff called an ambulance at 4.55am.
47. A nurse responded to the officer's call. She collected the emergency bag and defibrillator and arrived at Mr Mayhew's cell five minutes after the code blue. When she arrived, Mr Mayhew was lying on his back on the floor. He was not breathing and had no pulse, his eyes were fixed and glazed, and he displayed signs of rigor mortis. Another nurse arrived and they decided that resuscitation was not appropriate as rigor mortis was present, and it would have been futile and degrading for Mr Mayhew. Paramedics arrived at 5.12am and pronounced Mr Mayhew dead at 5.32am.

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

48. Two officers were appointed as family liaison officers and tried to visit Mr Mayhew's sister at 11.50am and 12.20pm but no one was at home. At 12.40pm, Durham gave them an address for Mr Mayhew's other sister, so they travelled for two hours but the address was wrong. They returned to the first address but no one was there. At 8.30pm, Mr Mayhew's sister telephoned them and told them that she had already found out about Mr Mayhew's death from a family friend. They subsequently visited her and offered support. Durham contributed to the cost of Mr Mayhew's funeral in line with national instructions.

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

49. After Mr Mayhew's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
50. The prison posted notices informing other prisoners of Mr Mayhew's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by his death.

### **Post-mortem report**

51. The post-mortem examination established that Mr Mayhew died from hanging. His toxicology report indicated therapeutic use of sertraline, fluoxetine, propranolol and previous use of chlordiazepoxide (medication for alcohol withdrawal). No illicit substances were detected.

# Findings

## Assessment of Mr Mayhew's risk

52. Prison Service Instruction (PSI) 64/2011 on safer custody lists a number of risk factors and potential triggers for suicide and self-harm. Mr Mayhew had a number of significant risk factors:
- He had been recalled to prison and had not expected to have to serve the rest of his sentence in prison.
  - He had misused alcohol.
  - He had a long history of attempted suicide and significant self-harm.
  - He had a history of mental ill health.
  - He had no family support and missed contact with his daughters.
53. In February 2016, we published a Learning Lessons bulletin on early days and weeks in custody. We identified that recall to prison after a breach of licence was a noticeable characteristic of several of the deaths within the first few weeks in prison, and recall was an inevitably distressing experience and a known risk factor for suicide and self-harm.
54. Reception staff did not review Mr Mayhew's licence revocation papers, person escort record or his historic clinical records. They were therefore not aware of his risk factors and did not start ACCT procedures. This was a missed opportunity to have identified Mr Mayhew's vulnerability, risks and needs early and to have put in place measures to address them appropriately. Contrary to PSI 64/2011, reception staff based their assessment of Mr Mayhew's risk on his presentation and what he said.
55. The Head of Safeguarding explained that staff giving prisoners recall papers should read and check them for any risk information and either inform the case manager if the prisoner is subject to ACCT monitoring or start ACCT procedures, if necessary. Mr Mayhew's recall papers explicitly noted that he had thoughts of suicide. An officer gave Mr Mayhew his recall papers on 6 January 2017 and his offender supervisor interviewed him later that day. We are concerned that neither the officer nor the offender supervisor started suicide and self-harm procedures, considered that Mr Mayhew was at increased risk, or appear to have discussed the impact of recall with Mr Mayhew. Not doing so was a missed opportunity to identify Mr Mayhew's risk at a potentially critical time (nine days before his death). We make the following recommendation:

**The Governor and Head of Healthcare should ensure that staff consider and share all available information and records about prisoners' risk appropriately, and that the specific risk factors associated with recalled prisoners are properly understood.**

## ACCT procedures

56. The probation officer appropriately started ACCT procedures on 19 December. PSI 64/2011 requires case reviews to be multidisciplinary where possible and for the first case review the assessor, the person who raised the initial concern and a healthcare representative must attend. While we recognise that an officer and a mental health nurse attended, the probation officer who started ACCT procedures for Mr Mayhew and who had knowledge of his history and risk, should have been invited to contribute.
57. Staff did not create a caremap for Mr Mayhew, and monitoring was stopped prematurely. Staff relied excessively on Mr Mayhew's presentation and denial of suicidal thoughts. They did not check his prison or clinical records during his ACCT assessment, case review or mental health assessment and, as a result, failed to identify his bipolar disorder, that he had self-harmed and attempted suicide in 2016 or that he had recently been discharged from a mental health hospital. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance. In particular:**

- **Staff should understand the importance of understanding prisoners' risk factors and not rely excessively on their presentation in deciding whether to start ACCT procedures.**
- **Case managers should receive effective ACCT training and understand their responsibilities to hold case reviews in line with national guidelines.**
- **ACCT case reviews should consider and record all available information and known risk factors when determining a prisoner's level of risk of suicide and self-harm.**
- **Staff should create ACCT caremaps with specific, meaningful and time-bound actions, aimed at reducing prisoners' risks to themselves, progress should be considered and updated at each review.**
- **Case reviews should include all relevant people involved in a prisoner's care, and in particular, the person who started ACCT procedures should be invited to or provide input to the first case review.**

## Clinical care

58. The clinical reviewer concluded that the care Mr Mayhew received was not equivalent to that which he would have received in the community. She found that key decisions about Mr Mayhew's care and treatment were made without full knowledge of Mr Mayhew's diagnosis. She makes a number of recommendations, which the Head of Healthcare will need to address.

## Mental health

59. The reception nurse appropriately referred Mr Mayhew to the mental health team. In the meantime, staff appropriately started ACCT procedures on 19 December and the mental health nurse was asked to complete a mental health assessment to inform Mr Mayhew's ACCT assessment. He did not check Mr Mayhew's historic clinical information or any other prison records to complete his assessment, as he should have done, and was unaware of Mr Mayhew's longstanding mental health issues and risk. We are concerned that he based his mental health assessment on Mr Mayhew's presentation and the limited information he gave him, and that his mental health referral was then cancelled without a thorough assessment based on all available clinical information about Mr Mayhew's mental health history. This was a missed opportunity to understand and appropriately treat Mr Mayhew's mental health needs and inform his management under ACCT procedures.
60. Although a nurse thought that Mr Mayhew should have seen a doctor in reception, this did not happen because it was too late in the day. We are concerned that when he did, three days later, notwithstanding Mr Mayhew's longstanding mental health needs, a prison GP stopped his prescription for olanzapine without knowledge of his recent psychiatric history and his diagnosis of bipolar disorder. His alcohol misuse was also not adequately addressed. We criticised the mental health services at Durham in a previous report and make the following recommendations:

**The Head of Healthcare should ensure that the healthcare team, including the mental health team, complete a full risk assessment for prisoners identified at risk of suicide and self-harm, that decisions when assessing prisoners, considering referrals and reviewing medication are made using all available information, and that reasons for decisions are clearly documented.**

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