

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Tuff a prisoner at HMP Hewell on 14 November 2017

A report by the Prisons and Probation Ombudsman

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141

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*



© Crown copyright 2017

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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.

My 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 John Tuff died from the toxic effects of psychoactive substances on 14 November 2017 at HMP Hewell. He was 36 years old. I offer my condolences to Mr Tuff's family and friends.

Mr Tuff had a history of substance misuse and mental health problems. He had been in prison many times before and, on this occasion, had been moved between four different establishments in a six-month period. I am concerned by the long delay in providing Mr Tuff with appropriate mental health support when he transferred from HMP Bullingdon to Hewell in June 2017. His mental health care was not equivalent to that which he could have expected to receive in the community.

My investigation also found that Hewell failed to follow its own Substance Misuse Strategy and that Mr Tuff was not adequately supported when he said he had been assaulted by other prisoners, which led to him feeling unsafe and staying locked in his cell.

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

October 2018

Contents

Summary	1
The Investigation Process	4
Background Information	5
Key Events	7
Findings.....	13

Summary

Events

1. Mr John Tuff was recalled to prison on 23 January 2017 and later charged with ten further offences, including attempted murder. He spent time at HMP Leicester, HMP Glen Parva and HMP Bullingdon before being transferred to HMP Hewell on 21 June 2017.
2. On arrival at Hewell, Mr Tuff's reception healthcare screening identified previous concerns about suicide and self-harm and that he was on the mental health caseload at Bullingdon. His mental health keyworker at Bullingdon had put an entry into his medical records to hand his care over to Hewell. The reception nurse made a referral to the mental health team. Further referrals were made on 11 September, 18 October, 22 October and 27 October. Mr Tuff was seen for an initial assessment on 1 November.
3. Mr Tuff was found to be under the influence of psychoactive substances (PS) on 19 and 29 July. A nurse made a referral to the substance misuse team on 31 July. The nurse also put him on the waiting list for a PS awareness group. Mr Tuff saw a support worker from the substance misuse team on 18 October. He told her that he needed support from the mental health team as he thought his PS use was due to his mental health issues.
4. On 22 October, Mr Tuff was seen by a nurse after he alleged that he had been assaulted. He told the nurse that he would self-harm if he was not moved from the houseblock. Staff started suicide and self-harm monitoring (ACCT procedures) but no one investigated the alleged assault. At the first ACCT case review on 23 October, Mr Tuff said he wanted to move to a different houseblock or a different prison and that he needed to see the mental health team. He saw his mental health keyworker for an initial assessment on 1 November.
5. At approximately 8.20pm on 14 November, an officer went to carry out an hourly ACCT observation on Mr Tuff but he had covered the observation panel and she could not see into his cell. The officer failed to get a response from Mr Tuff and thought she could see blood on the cell floor when looking under the door. She radioed for emergency assistance and waited outside the cell. When a custodial manager arrived, both members of staff entered the cell at approximately 8.28pm. They found Mr Tuff unresponsive on the floor and started cardiopulmonary resuscitation (CPR). Two members of healthcare staff arrived shortly afterwards but they did not take part in the CPR. Paramedics arrived at approximately 8.40pm but they could not resuscitate Mr Tuff and he was pronounced dead at approximately 9.30pm.

Findings

6. The prison failed to provide adequate mental health support to Mr Tuff. A telephone handover by his mental health nurse at Bullingdon was overlooked and, despite three further referrals, Mr Tuff did not receive any support from the mental health team at Hewell until nearly five months after his arrival.

7. ACCT reviews were not held in accordance with PSI 64/2011 as they were not multidisciplinary. We were concerned to find that there was limited input from healthcare and, in particular, that there was no input from the mental health team at any of the reviews.
8. There was a delay in getting appropriate support for Mr Tuff's substance misuse problems at Hewell. A referral was made on 31 July but his first appointment with a substance misuse worker did not take place until 18 October. Mr Tuff did not have a mandatory drug test until 6 November, which was not in line with the prison's Substance Misuse Strategy.
9. The prison did not investigate the alleged assault against Mr Tuff in line with their own Violence Reduction Strategy.
10. There was a delay of approximately nine minutes between an officer failing to get a response from Mr Tuff and entering his cell to start CPR. Mr Tuff was on an ACCT and he had covered the observation panel on his cell. We consider the officer carrying out the ACCT check should have acted more quickly when she did not get a response from him. While we do not consider this affected the eventual outcome for Mr Tuff, such a delay could be critical in future cases.
11. We also found that healthcare staff did not respond appropriately to the emergency.

Recommendations

- The Head of Healthcare should ensure that mental health services meet the needs of prisoners by:
 - implementing a referral system that results in a timely, face-to-face assessment using all relevant information for appropriate continuity of care and follow-up;
 - ensuring there is appropriate follow-up by healthcare staff when a prisoner misses their medication; and
 - ensuring prisoners have access to services equivalent to those in the community.
- The Head of Healthcare should ensure that healthcare staff take a lead role in resuscitation until paramedic staff can attend or until death is confirmed.
- The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide and self-harm in line with PSI 64/2011, in particular that there is a multi-disciplinary approach for all case reviews with relevant healthcare staff and other keyworkers providing detailed input if they are unable to attend.

- The Governor and Head of Healthcare should:
 - ensure that mandatory drug testing is carried out in line with the prison's Substance Misuse Strategy in order to reduce the demand and deter the use of illicit substances;
 - amend the prison's Substance Misuse Strategy to include reasonable timescales for prisoners referred to substance misuse services to be offered an initial assessment; and
 - ensure that prisoners on waiting lists for psychosocial or group work are offered regular, face-to-face sessions with a substance misuse worker while they are waiting.
- The Governor should ensure that all incidents of violence are investigated in accordance with PSI 64/2011 and Hewell's own Violence Reduction Strategy, including providing feedback on the investigation to the victim and ensuring that details of the investigation are appropriately documented.
- The Governor should ensure that staff are given clear, written guidance on what to do if they cannot see or get a response from prisoners being monitored under ACCT procedures so that assistance can be provided promptly.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Hewell informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
13. The investigator obtained copies of relevant extracts from Mr Tuff's prison and medical records.
14. NHS England commissioned a clinical reviewer to review Mr Tuff's clinical care at the prison.
15. The investigator and clinical reviewer jointly interviewed ten members of staff at HMP Hewell. The clinical reviewer interviewed one member of healthcare staff by telephone. The interviews took place between February and May 2018.
16. We informed HM Coroner for Worcestershire of the investigation who sent the results of the post-mortem examination to us. We have given the coroner a copy of this report.
17. One of the Ombudsman's family liaison officers contacted Mr Tuff's mother to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. Mr Tuff's mother was concerned that her son may have been under threat from other prisoners. She wanted to know why he had facial injuries when he died.
18. Mr Tuff's family received a copy of the initial report. They did not raise any concerns regarding factual accuracy of this report.
19. The initial report was shared with Her Majesty's Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Hewell

20. HMP Hewell has two sites. One operates as an open prison, the other as a medium security, local prison. Mr Tuff was housed at the latter site, which comprises six houseblocks, holding around 1,100 men. Care UK provides health services at Hewell.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Hewell was in September 2016. Inspectors reported that security was well-managed and generally proportionate, but the availability of drugs remained very high. Mandatory drug testing had exceeded the target for the previous 12 months and 60% of prisoners said that it was easy to obtain illegal drugs. Despite the prevalence of drugs, inspectors found that supply reduction initiatives were developing well and there was effective joint working between security and other departments represented at the drug strategy committee.

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 their latest annual report, for the year to 30 September 2017, the IMB reported that staff and prisoners felt the prison was not safe. Incidents involving psychoactive substances (PS) were regularly reported in the daily briefings but the ready availability of these illicit substances continued to put staff and prisoners at risk.

Previous deaths at HMP Hewell

23. Mr Tuff was the 12th prisoner to die at Hewell since November 2014. Four of the previous deaths involved prisoners taking their own lives and one was drug related. The remaining deaths were due to natural causes. Since Mr Tuff's death, there has been a further death at Hewell involving the use of illicit drugs.

Assessment, Care in Custody and Teamwork

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.
25. 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 multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (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.

26. 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.

Psychoactive substances (PS)

27. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious 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 PS 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.
28. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time 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 PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
29. 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.

Mandatory drug testing (MDT)

30. Prisoners are legally required to provide a sample, on request, for the purposes of drug testing. While MDT alone cannot solve the problem of drugs within prisons, it can contribute to the overall objective of reducing drug misuse when used as part of a wider and more comprehensive drug strategy. The objectives of MDT are to increase the detection of those misusing drugs, to help prisoners resist peer pressure to become involved in drug taking, to offer appropriate support to those who want to combat their drug problems, and to help identify the scale, trend, types and patterns of drug misuse in individual establishments. Prison Service Order (PSO) 3601 sets out the procedures and mandatory requirements for carrying out MDT. Target levels of between 5-15% of the prison population are expected to be randomly tested each month. Additional testing can take place if prisoners are suspected of using illicit drugs.

Key Events

HMP Leicester 23 January – 28 March 2017

31. Mr John Tuff arrived at HMP Leicester on 23 January 2017. He had been released on licence from Leicester two months previously but was recalled to custody for allegedly committing further offences. Staff started suicide and self-harm monitoring (under the process known as ACCT) after he reported that he had been self-harming in the community. He was also allocated a substance misuse worker and started a methadone programme. Staff stopped ACCT monitoring on 7 February.
32. By 7 March, Mr Tuff had reduced his methadone dose from 20ml to 7ml and said he no longer needed support with substance misuse. However, he asked to see someone about his mental health, so the substance misuse worker referred him to the mental health team.
33. On 15 March, Mr Tuff self-harmed by cutting his hand. He said he did this as he had not been seen by the mental health team. Staff started ACCT monitoring but stopped it on 24 March.
34. On 25 March, Mr Tuff was found to be under the influence of an illicit substance. A targeted search of his cell on 28 March found illicit substances and an improvised weapon and he was placed on report. Mr Tuff was transferred to HMP Glen Parva later that day.

HMP Glen Parva 28 March – 24 May 2017

35. On 6 April, Mr Tuff was assessed by the mental health team at Glen Parva and taken onto their caseload. He told a nurse that he was hearing voices and that he had previously been diagnosed with psychosis when he was 14 years old. He said the voices told him to harm himself but that he did not have any current thoughts of suicide or self-harm.
36. On 10 April, Mr Tuff was assessed by the substance misuse team and said he did not want any support, so he was discharged from their caseload.
37. Mr Tuff was assessed by a psychiatrist on 21 and 28 April, who increased his antidepressant and antipsychotic medication.
38. On 24 May, Mr Tuff attended court where he was charged with ten further offences, including attempted murder. He was remanded to custody and transferred to HMP Bullingdon. During his time at Bullingdon he had an allocated community psychiatric nurse (CPN) and was scheduled to see a psychiatrist on 19 June. This appointment was postponed to 21 June but did not go ahead as Mr Tuff attended court on that date and was transferred from court to HMP Hewell.

HMP Hewell 21 June – 14 November 2017

39. On arrival at Hewell on 21 June, a nurse carried out a healthcare screening. He noted that Mr Tuff was under the care of the mental health team at Bullingdon and he therefore made a referral to the mental health team at Hewell. He also

noted that there were minor concerns about suicide and self-harm and that Mr Tuff had been monitored under ACCT procedures in March 2017. The nurse told the investigator and the clinical reviewer that Mr Tuff appeared very anxious about being attacked by other prisoners who knew the victim of his offence. He said he assessed Mr Tuff's cell sharing risk as high so that he would be placed in a cell on his own.

40. On the basis of Mr Tuff's previous prescriptions, a nurse prescribed mirtazapine (antidepressant), quetiapine (antipsychotic) and an asthma inhaler, but she did not see Mr Tuff.
41. On 22 June, a nurse made a note in Mr Tuff's medical record to say that he had been discharged from the mental health service at Bullingdon. The nurse noted that she had contacted Hewell's mental health team by telephone that afternoon to hand over Mr Tuff's care but she did not record who she had spoken to and Hewell had no record of the contact she had made.
42. On the evening of 19 July, staff made a request for healthcare to see Mr Tuff in his cell as he was suspected of having been under the influence of PS earlier in the day. A prison paramedic saw Mr Tuff and made a note in his records that Mr Tuff declined to be assessed by him. He also noted that healthcare had not been informed earlier in the day when Mr Tuff was suspected of being under the influence.
43. On 29 July, an officer found Mr Tuff unresponsive in his cell after using PS. The officer called an emergency code blue. The prison paramedic responded and found Mr Tuff to be conscious but noted he was aggressive and did not want to be medically assessed. Although an ambulance had been called, it was cancelled as Mr Tuff refused any intervention. The paramedic noted that Mr Tuff had used his asthma inhaler as a pipe to use PS. He told the investigator and the clinical reviewer that he was concerned about Mr Tuff and he wanted him to be admitted to the healthcare centre for observation but there were no spaces available. He said he discussed his concerns with the prison staff and asked that they observe Mr Tuff every ten minutes. He wrote in Mr Tuff's medical notes that there was a high risk of further overdose or death.
44. On 31 July, a nurse had a follow up appointment with Mr Tuff to discuss his use of PS. He noted that Mr Tuff said he wanted help with PS and he referred him to the psychosocial team and put him on the waiting list for the PS awareness group.
45. On 1 August, Mr Tuff was again found to be under the influence of PS. A prison GP stopped Mr Tuff from having his asthma inhaler in his possession as he had been using it for PS.
46. On 11 September, Mr Tuff told a nurse that he had received a psychiatric report from Rampton Hospital and he needed to see someone from the mental health team. The nurse referred Mr Tuff to the mental health team. Another nurse actioned the referral on 23 September and noted that Mr Tuff had previous involvement with mental health teams and that he had been referred at reception by a nurse. She wrote in Mr Tuff's medical record that his referral was accepted

and that he was placed on a waiting list for a full mental health assessment, blood tests and echocardiogram (ECG – a test to check the heart’s rhythm).

47. On 18 October, Mr Tuff met a substance misuse support worker for the first time. He was still waiting to be seen by the mental health team and was still on the waiting list to attend the PS awareness group. The substance misuse support worker wrote in Mr Tuff’s medical record that she had a brief discussion with him about the use of unknown substances in the prison environment and the risk of overdose. She noted that Mr Tuff said his father had died in October 2016 and that he had not dealt with his death. She suggested that he meet with chaplaincy to discuss this further. She told the investigator and the clinical reviewer that Mr Tuff wanted to engage with the mental health team rather than the substance misuse team as he felt that his use of PS was caused by his mental health problems. She said that she immediately spoke to Mr Tuff’s allocated mental health keyworker to ask her to assess him. She said that she was due to leave so she was keen to hand over Mr Tuff’s care to someone in the team. She noted that Mr Tuff was due to meet his mental health keyworker on 19 October. This appointment did not take place.
48. On 22 October, Mr Tuff was seen by a healthcare assistant after he said that three prisoners had come to his cell and kicked him in his head and chest. The healthcare assistant noted minor injuries and scratches to his forehead. Mr Tuff told her that he would self-harm if he was not moved from Houseblock 6 as he was afraid of further assaults. He also said that he needed to see the mental health team. The healthcare assistant made a further referral to the mental health team for an urgent review and also contacted a supervising officer (SO). The SO started ACCT monitoring.
49. The first ACCT case review on 23 October was chaired by a custodial manager (CM), and also attended by an officer. The CM assessed Mr Tuff’s risk as low and he recorded that the ACCT would remain open for another 72 hours with a view to moving Mr Tuff to another houseblock. The record of the ACCT review made no mention of the alleged assault on Mr Tuff and there was no input from healthcare staff. The Head of Safer Custody told the investigator that the prison did not immediately investigate the alleged assault due to a shortage of staff at the time.
50. The second ACCT case review took place on 26 October and Mr Tuff’s risk was assessed as low. The review was chaired by a SO and attended by an officer. Mr Tuff said that he was in fear for his safety at Hewell and that he wanted to move to another prison. He said he was not mixing with other prisoners and was not taking his medication. The record of the ACCT review states that there was written input from healthcare but it is not clear what this input was or who provided it. However, the SO noted that healthcare had told him Mr Tuff was not taking his medication.
51. On 27 October, Mr Tuff self-harmed by cutting his arm and wrist. A nurse treated his injuries and he told her that he needed to see the mental health team urgently. The nurse wrote in Mr Tuff’s medical record that she had some concerns about him but she noted he was already being monitored under ACCT procedures.

However, she sent a referral to the mental health team asking for an urgent mental health review.

52. On 31 October, Mr Tuff attended his third ACCT review which was chaired by a SO and also attended by an officer on Houseblock 6. A verbal report was provided by a nurse but the detail is not recorded. Staff noted that Mr Tuff remained locked in his cell and that he would only consider a transfer to another prison. The ACCT document noted that Mr Tuff could not be transferred as he was a remand prisoner, but the caremap was noted to say that Mr Tuff's request for a transfer would be escalated to the Governor. Staff assessed Mr Tuff's risk as low and agreed to continue ACCT monitoring.
53. On 1 November, Mr Tuff had a mental health assessment with his mental health keyworker, a mental health nurse. At interview, she said she had been due to see Mr Tuff two weeks previously but had been on sick leave and then on annual leave. She did not know why there was a delay in Mr Tuff's case being allocated to the mental health team and said she had only been aware of him after the substance misuse worker spoke to her on 18 October. The mental health team manager was also unable to explain why the numerous referrals to her team had been missed.
54. The mental health keyworker recorded that Mr Tuff told her his mental health problems started when he was around 13 years old and he had been diagnosed with ADHD, anxiety and depression. He told her that he was now disturbed by hearing three different voices and that he had not taken his medication as he was afraid to come out of his cell to collect it. Mr Tuff told his keyworker that he was continuing to use PS in prison as he was finding it difficult to cope and he was not getting any support for his mental health issues. The keyworker was concerned about Mr Tuff so she submitted an incident report (Datix) to the healthcare trust highlighting the risks of Mr Tuff being locked in his cell and missing his medication.
55. The keyworker also discussed Mr Tuff's case at a weekly mental health multidisciplinary meeting (MDT) the following day. A psychiatrist said that Mr Tuff's antipsychotic and antidepressant medication would have to be stopped for safety reasons as he had missed a number of doses and was using illicit substances. She said Mr Tuff was upset and tearful when she saw him on 3 November and told him that his medication would have to be stopped and reviewed by the psychiatrist. She requested that this should be done urgently, but she said Mr Tuff did not go to the appointment because he was afraid to leave his cell so the medication review and necessary tests did not happen. She said she agreed to see Mr Tuff every three days to offer him support.
56. Mr Tuff had his first mandatory drug test on 6 November.
57. On 7 November, Mr Tuff attended his fourth ACCT case review. The review was chaired by a SO and a nurse was again recorded as providing input, the content of which is, again, unknown. Mr Tuff's risk was assessed as low and it was noted that there was no real change in his situation. He continued to self-isolate and requested a move away from Houseblock 6. Mr Tuff said that he would like to be transferred back to Bullingdon. The SO told the investigator and the clinical reviewer that there were challenges in relocating Mr Tuff due to his remand

status and his high risk of cell sharing. Despite the keyworker's recent engagement with Mr Tuff, she was not invited to attend the ACCT review.

58. On the afternoon of 14 November, Mr Tuff attended his fifth ACCT case review which was chaired by a SO and also attended by an officer. No one from healthcare attended or provided any input. Mr Tuff was frustrated that an arranged legal visit from his solicitor had not taken place earlier that day and he said that he still had thoughts of self-harm. The SO recorded that he told Mr Tuff that staff were still looking into moving him away from Houseblock 6 or transferring him out of Hewell. Mr Tuff's risk was assessed as low and the next case review was set for 21 November.
59. At 6.50pm on 14 November, after all the other prisoners had been locked in their cells for the night, an officer unlocked Mr Tuff so that he could have a shower. He locked Mr Tuff back into his cell at 7.15pm and recorded that he appeared in good spirits. CCTV shows that during the period he was unlocked, Mr Tuff took a small package from under the door of a neighbouring cell.
60. An officer went to carry out an hourly ACCT observation on Mr Tuff at approximately 8.20pm, but she could not see into his cell as he had covered the observation panel. She was unable to get a verbal response from Mr Tuff so she tried to look into the cell through the door frame. CCTV shows that the officer spent approximately three minutes trying to get a response from Mr Tuff. She then saw what she thought was blood on the floor of the cell, so she radioed an emergency code red. The officer told the investigator and the clinical reviewer that she was on her own on the unit because there had been an incident on another houseblock which required staff attendance. She said she had no knowledge of Mr Tuff so she did not consider it safe for her to go into the cell until one of her colleagues arrived. She did not say why she waited three minutes before calling for assistance but she said that, after calling the code red at 8.24pm, she made a further call on her radio for assistance around 8.27pm.
61. A CM came onto the unit at approximately 8.28pm and the officer immediately opened the cell door. The officer said that Mr Tuff was lying on the floor with vomit and blood beside him. She described his appearance as grey and waxy and she believed he was dead. She immediately started cardiopulmonary resuscitation (CPR) while the CM radioed for further assistance. An officer arrived at approximately 8.28pm, closely followed by a nurse. The officer went into the cell and took over CPR. CCTV shows the nurse immediately turn and walk down the landing away from the cell, returning shortly after with a healthcare assistant, who was carrying the emergency bag. They both stood outside the cell before the nurse walked off down the landing again at 8.33pm, leaving the healthcare assistant standing outside the cell. The nurse returned to the landing at 8.36pm with the paramedics who took over resuscitation attempts before pronouncing Mr Tuff dead at approximately 9.05pm.

Contact with Mr Tuff's family

62. Mr Tuff's mother was listed as his next of kin. A SO and a prison chaplain from HMP Highpoint visited Mr Tuff's mother at her house on 15 November at approximately 2am to inform her of her son's death. HMP Hewell's appointed family liaison officers subsequently made ongoing contact with Mr Tuff's mother.

The prison contributed to the cost of Mr Tuff's funeral, in line with Prison Service instructions.

Support for prisoners and staff

63. Staff involved in the emergency response attended a debrief led by a senior manager.
64. The Deputy Governor posted a notice for prisoners informing them of Mr Tuff's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Tuff's death.

Post-mortem report

65. The post-mortem found that Mr Tuff's death was due to the toxic effects of PS. The post-mortem did not say how Mr Tuff may have acquired facial injuries, but a possible explanation is that Mr Tuff suffered a fit and injured himself on furniture in the cell. The police were satisfied there was no third party involved in Mr Tuff's death.

Findings

Mental health care

66. Mr Tuff had engaged with mental health services in previous prisons before arriving at Hewell. His medical record shows a handover from a nurse at Bullingdon on 22 June but Hewell could not trace who had received her phone call. Despite this, the nurse had provided a clear written record of Mr Tuff's mental health needs, including the fact that he had a pending psychiatric appointment which needed to be followed up. Additionally, a nurse at Hewell flagged this up to the mental health team when he did Mr Tuff's reception healthcare screening.
67. Four further referrals were made by healthcare staff at Hewell but Mr Tuff was not seen for an initial mental health assessment until 1 November. By this time, he had been using illicit drugs and he had told staff he was using drugs because he was not getting support for his mental ill-health. He was also self-isolating and he had not been taking his prescribed medication.
68. Mr Tuff waited 19 weeks from the date of his arrival at Hewell to receive an initial assessment by the mental health team. The clinical reviewer said that this waiting time was outside of NHS expected standards and that, therefore, Mr Tuff's mental health care was not equivalent to that which he could have expected to receive in the community. We make the following recommendation:

The Head of Healthcare should ensure that mental health services meet the needs of prisoners by:

- **implementing a referral system that results in a timely, face-to-face assessment using all relevant information for appropriate continuity of care and follow-up;**
- **ensuring there is appropriate follow-up by healthcare staff when a prisoner misses their medication; and**
- **ensuring prisoners have access to services equivalent to those in the community.**

ACCT reviews

69. Prison Service Instruction (PSI) 64/2011 states that ACCT case reviews should be multidisciplinary and reflect the prisoner's level of risk. Mr Tuff attended five case reviews between 22 October and 14 November and healthcare staff did not attend any of these reviews. Although healthcare provided verbal input to two reviews, we found that this input was limited in content and did not assist in identifying any possible risks to Mr Tuff, such as when he stopped taking his medication. Although Mr Tuff was engaging with the mental health team, we were concerned to find that his keyworker was not invited to attend the case reviews or to provide input. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide and self-harm in line with PSI 64/2011, in particular that there is a multidisciplinary approach for all case reviews

with relevant healthcare staff and other keyworkers providing detailed input if they are unable to attend.

Substance misuse

70. Hewell's Substance Misuse Strategy includes a number of initiatives to tackle the supply and demand of illicit drugs. This includes gathering and sharing security information around drug supply, physical searching of prisoners and visitors, closed visits and surveillance for those considered to pose a risk of bringing drugs into the prison. The policy identifies mandatory drug testing as a means of reducing the demand for illicit drugs by acting as a deterrent, and states *"prisoners testing positive for Class 'A' drug misuse or more than once for Class 'B/C' drug or suspected of NPS misuse will be automatically subjected to a Frequent MDT testing programme"*.
71. By the time Mr Tuff arrived at Hewell, he had been through a drug detoxification programme at Leicester between January and March 2017, and there were no concerns about substance misuse. However, from 19 July there were regular reports of Mr Tuff being under the influence of PS and a referral was made to the substance misuse service after a serious incident where he collapsed. Despite this, Mr Tuff did not have his first mandatory drug test until 6 November, which proved positive for cannabis and PS, and the results were made available on the day of his death. We consider that Mr Tuff should have been subjected to mandatory drug testing at an earlier date, in line with the prison's policy.
72. Mr Tuff agreed to engage with psychosocial work and, on 31 July, he was put on a waiting list to attend a PS awareness group. Mr Tuff did not see anyone from the substance misuse team again until 18 October. During this time, he remained on the PS awareness group waiting list and was continuing to use PS. The prison's Substance Misuse Policy states, *"It is imperative that the Substance Misuse service is easily accessible to all who wish to engage in psychosocial interventions around their drug use"*, and it also states various avenues for referrals to be made to the service, including self-referral. However, it does not give an expected timescale for support to be made available after a referral has been made. We consider that a wait of over three months was too long, especially given Mr Tuff's previous substance misuse history. We therefore make the following recommendation:

The Governor and Head of Healthcare should:

- **ensure that mandatory drug testing is carried out in line with the prison's Substance Misuse Strategy in order to reduce the demand and deter the use of illicit substances;**
- **amend the prison's Substance Misuse Strategy to include reasonable timescales for prisoners referred to substance misuse services to be offered an initial assessment; and**
- **ensure that prisoners on waiting lists for psychosocial or group work are offered regular, face-to-face sessions with a substance misuse worker while they are waiting.**

Violence reduction strategy

73. Mr Tuff threatened to self-harm after he said he was assaulted in his cell on 22 October. Staff started ACCT monitoring but we found no evidence that the alleged assault was investigated or that Mr Tuff was appropriately supported.
74. The prison's Violence Reduction Strategy states, "*When a violent incident occurs the quality of follow up action and support may make the difference between long term harm and quick physical emotional and psychological recovery.*" It also says that the prison aims to, "*...keep prisoners safe by relocating the perpetrators of violence and/or if necessary the victim*". Although Mr Tuff said at ACCT reviews that he was self-isolating because he remained in fear for his safety after the alleged assault, no one thought to start an investigation or to prioritise his relocation to a different houseblock.
75. We found that the allegations of assault were not investigated until after Mr Tuff's death and we heard that this was due to resource implications at the time. While we accept that Mr Tuff was offered some support from the ACCT process, we find it unacceptable that his fears for his safety were not investigated through the appropriate channels and that he felt he had no option but to self-isolate – to the point where he was not collecting his medication or attending medical appointments - to keep himself safe. We make the following recommendation:

The Governor should ensure that all incidents of violence are investigated in accordance with PSI 64/2011 and Hewell's own Violence Reduction Strategy, including providing feedback on the investigation to the victim and ensuring that details of the investigation are appropriately documented.

Emergency response

76. On the evening of 14 November, an officer was covering two prison wings alone because her colleague had been called away to assist with an incident on another houseblock. When she went to check on Mr Tuff, he had covered his observation panel and she was unable to get a response from him. She spent around three minutes trying to see into his cell before calling for assistance on her radio when she thought she could see blood on the floor of his cell.
77. We consider it reasonable that the officer waited for a CM to arrive before opening the cell door as she could not tell whether it was safe to enter the cell alone. However, this resulted in an overall delay of nearly nine minutes between the officer arriving at Mr Tuff's cell to carry out the ACCT check and entering his cell to start CPR. We consider that the officer should have raised the alarm as soon as she found she could not get a response from Mr Tuff, given that he was on an ACCT and had covered his observation panel. While we do not consider this affected the eventual outcome for Mr Tuff, such a delay could be critical in future similar cases and we make the following recommendation:

The Governor should ensure that staff are given clear, written guidance on what to do if they are unable to see or get a response from prisoners being monitored under ACCT procedures so that assistance can be provided promptly.

78. Two officers and a CM carried out CPR without the support of healthcare staff who had responded to the emergency but remained outside the cell. The nurse only went into the cell when the paramedics arrived and the healthcare assistant did not go into the cell at all. We do not consider that this was an appropriate response from healthcare staff and we make the following recommendation:

The Head of Healthcare should ensure that healthcare staff take a lead role in resuscitation until paramedic staff can attend or until death is confirmed.

**Prisons &
Probation**

Ombudsman
Independent Investigations