

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daniel Davey a prisoner at HMP Bullingdon on 12 January 2018

A report by the Prisons and Probation Ombudsman

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 Daniel Davey died on 12 January 2018 at the a hospital after taking an overdose of prescribed medication at HMP Bullingdon. He was 21 years old. I offer my condolences to Mr Davey's family and friends.

Although prison staff started suicide and self-harm prevention procedures on two occasions, they over-relied on Mr Davey's presentation and did not consider all his risk factors. There were also failings in the management of those procedures.

There were errors in the assessment of Mr Davey's suitability to hold medication in-possession and the assessment was not subsequently reviewed or updated. There were also avoidable delays in calling an emergency ambulance and facilitating its access to the prison.

It is troubling that this investigation has found issues relating to suicide prevention measures and emergency vehicle access similar to those identified in investigations into previous deaths at the prison. The Director for the South Central Group should assure himself that these issues are now properly addressed.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation. It also reflects the fact that after the publication of my final report, Her Majesty's Prison and Probation Service (HMPPS) has provided us with a response and an action plan in respect of our recommendations.

Sue McAllister CB
Prisons and Probation Ombudsman

April 2019

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Summary

Events

1. On 1 December 2017, Mr Daniel Davey received a sentence of ten years and six months imprisonment. He was sent to HMP Bullingdon. Mr Davey had a history of suicide and self-harm and had been diagnosed with a personality disorder, anxiety and depression. He was prescribed medication and was placed under the care of Bullingdon's mental health team.
2. During his initial health screening, a nurse started suicide and self-harm prevention monitoring procedures (known as ACCT) because Mr Davey had self-harmed in the past. Mr Davey was managed under ACCT procedures over two periods at Bullingdon: from 1 to 9 December 2017 and from 7 to 10 January 2018.
3. The nurse also assessed him as suitable to hold medication in possession. The medication included propranolol tablets, for anxiety. Staff dispensed propranolol to Mr Davey on a daily basis. He did not take all his tablets and saved them up in his cell.
4. On 11 January, at around 10.00pm, Mr Davey began vomiting in his cell. An officer attended and called healthcare staff who advised keeping Mr Davey under observation. Around five minutes later, Mr Davey started fitting and an emergency was called. Staff attended and Mr Davey, who was able to speak, told them that he had taken an overdose of propranolol. A nurse requested an ambulance and asked a colleague to call a substance misuse help-line for advice.
5. At around 10.50pm, the ambulance arrived at the prison gate and, ten minutes later, paramedics reached Mr Davey's cell. Mr Davey went into cardiac arrest and paramedics started resuscitation. Mr Davey was taken to the hospital where a doctor pronounced him dead at 12.31am.

Findings

6. Mr Davey presented with many risk factors for suicide and self-harm at Bullingdon. These included the nature of his offence, it being his first time in custody, and a history of suicide attempts and of self-harm. In December 2017, he told a nurse that he had a plan to kill himself. Mr Davey also suffered from a personality disorder, which carried a raised risk of impulsive, self-harming and suicidal behaviour.
7. Although staff appropriately placed Mr Davey on ACCT monitoring on two occasions they should not have stopped the monitoring when they did as Mr Davey remained at risk of suicide and self-harm.
8. We found many deficiencies in Mr Davey's ACCT management, including failure to gather relevant information before assessments and reviews, case reviews not being multidisciplinary, the caremap of the second ACCT not being completed and updated properly, and staff not being adequately trained.
9. The reception assessment of Mr Davey's risk of holding in-possession medication did not take into account his known risk factors for suicide and self-

harm or his background. Staff missed opportunities to review or update the assessment, most notably as part of the ACCT process.

10. The clinical reviewer concluded that the healthcare provided to Mr Davey was not equivalent to that which he could have expected to receive in the community. The clinical reviewer was concerned that Mr Davey's prescription of propranolol, although not in itself harmful, exceeded national guidelines and should have been reviewed. He was also concerned that healthcare staff did not monitor Mr Davey's mental health effectively following a reduction in his medication.
11. There was a significant delay in calling an ambulance and an avoidable delay in paramedics reaching Mr Davey's cell from the prison's gate.
12. In previous PPO investigations we made similar findings about assessment of the risk of suicide and self-harm and delay in providing ambulance access to the prison. Although the prison accepted our recommendations, Mr Davey's case indicates that more robust action needs to be taken.

Recommendations

- The Head of Healthcare should ensure that staff clearly record the reasons for prescribing higher doses of medication than advised in national guidelines, and that an effective system is put in place for healthcare staff to review and monitor a prisoner's mental health, following any changes in his medication;
- The Head of Healthcare and Prison Pharmacy should ensure staff regularly update risk assessments for prisoners holding in-possession medication and trigger ad hoc updates, particularly when an ACCT document is open;
- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular that they:
 - identify all the known risk factors of a prisoner and share information to provide collaborative care and treatment, in particular ensuring effective joint working between healthcare and prison staff when there are concerns about a prisoner's mental health;
 - assess a prisoner's risk considering his circumstances and risk factors and not just his personal presentation;
 - ensure a trained ACCT assessor use all relevant information to complete the ACCT assessment, including consulting with healthcare staff;
 - complete caremaps at the first ACCT case review which must be appropriately updated thereafter, setting out specific and meaningful actions, including inviting the family where appropriate and identifying who is responsible for actions and reviewing progress at each review;
 - conduct ACCT post-closure interviews as specified in the national instructions and local policy; and
 - undertake relevant training which is regularly updated.

- The Governor should:
 - review arrangements for emergency vehicles' access to the prison to reduce avoidable delays; and
 - ensure that all prison and healthcare staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies as outlined in the local Medical Emergency Response Code Protocol so that there is no delay in calling, directing, discharging or allowing access to ambulances in to the prison.
- The Prison Group Director for the South Central Group should assure himself that meaningful action is taken to address our recommendations.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Bullingdon informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
14. The investigator obtained copies of relevant extracts from Mr Davey's prison and medical records.
15. NHS England commissioned a clinical reviewer to review Mr Davey's clinical care at the prison.
16. The investigator interviewed 10 members of staff at Bullingdon on 14 and 15 March 2018 jointly with the clinical reviewer.
17. We informed HM Coroner for Oxfordshire of the investigation. He gave us the result of the post-mortem report and we have sent the Coroner a copy of this report
18. One of the Ombudsman's family liaison officers contacted Mr Davey's father to explain the investigation and to ask whether he had any matters he wanted the investigation to consider. Mr Davey's father wanted to know:
 - whether Mr Davey's medication should have been monitored closely;
 - whether staff considered Mr Davey's risk factors for suicide and self-harm;
 - the rationale for the staff decision to close Mr Davey's ACCT monitoring before he killed himself, and;
 - whether decisions around reducing Mr Davey's medication were adequate.
19. Mr Davey's family received a copy of the initial report. They wrote to us through their legal representatives. They made comments about the content of our report which we have addressed in separate correspondence. We have also made minor amendments to the initial report as a result.
20. We shared our initial report with Her Majesty's Prison and Probation Service (HMPPS) so it could check its factual accuracy and provide us with an action plan to address our recommendations.
21. Prior to the publication of this report on our website we received HMPPS' response and action plan. Although we have made minor changes to our final report, none of these impact our recommendations.

Background Information

HMP Bullingdon

22. HMP Bullingdon is a local prison, serving the courts of Oxfordshire and Berkshire. It holds up to 1,114 men. Care UK has been the healthcare provider since 1 April 2016. Cotswold Medicare Ltd provides general practitioner services. South Staffordshire and Shropshire NHS Foundation Trust provide care for those with severe and enduring mental illness and secondary mental health services.

HM Inspectorate of Prisons

23. The report of the most recent inspection of Bullingdon was conducted in May 2017. Inspectors reported that Bullingdon was not safe enough. ACCT case management for prisoners at risk of suicide or self-harm was weak and disorganised. Most staff did not have up-to-date ACCT training.
24. Inspectors found that interviews with the first night officer and health services staff lacked privacy and there was no structured assessment of risk factors for suicide and self-harm. They were concerned because recent investigations by the PPO following three self-inflicted deaths in custody had highlighted weaknesses in identifying risk on arrival. Although there was an action plan addressing recommendations from the PPO following the self-inflicted deaths, and some of these had been implemented, other crucial ones had not. Inspectors were also not confident that all near-fatal incidents were either consistently identified or properly investigated to learn lessons.

Independent Monitoring Board

25. 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 to 30 June 2017, the Board noted that staff shortages undermine the effectiveness of much of what the prison seeks to do, including holding prisoners safely. The Board found more improvement was required in the use of ACCTs.
26. The Board noted that Care UK had been appointed to provide primary healthcare in April 2016, and that staff recruitment had been a major challenge.

Previous deaths at HMP Bullingdon

27. This was the eighth self-inflicted death at HMP Bullingdon since 2015. In the previous death, we found that the decision of prison staff to reduce the level of ACCT observations was misjudged and that risk had not been properly assessed. We also found that there was a delay in the ambulance gaining access to the prison and made a recommendation to address this.

Assessment, Care in Custody and Teamwork (ACCT)

28. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to

reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Care Programme Approach (CPA)

29. The Care Programme Approach (CPA) is an NHS system of delivering community mental health services to individuals diagnosed with a severe mental illness or other vulnerabilities such as a history of violence or self-harm. Someone who needs CPA support should have a formal written plan that outlines any risks and a CPA care coordinator to organise and review the plan.

Emotionally Unstable Personality Disorder (EUPD)

30. Also known as Borderline Personality Disorder (BPD). Patients might be diagnosed with EUPD if they experience at least five of the following symptoms, which have lasted for a long time or have an impact on the patient's daily life:
- feeling very worried about people abandoning them, and being prepared to do anything to stop that happening; having very intense emotions that last from a few hours to a few days and capable of changing quickly;
 - not having a strong sense of identity which can change significantly depending on who they are with; finding it very hard to make and keep stable relationships; feeling 'empty' for much of the time;
 - acting impulsively and doing things that could harm them (such as binge eating, using drugs or driving dangerously); and
 - self-harming or have suicidal feelings; having very intense feelings of anger which are difficult to control; experiencing paranoia or dissociation when very stressed.

Key Events

31. On 1 December 2017, Mr Daniel Davey received an extended sentence of 10 years and six months. This comprised a custodial term of six years, six months and an extension period of four years, for sexual offences against a child (a member of his family). Mr Davey was sent to HMP Bullingdon. It was his first time in prison. Mr Davey's Person Escort Record (PER, a document that accompanies prisoners as they move between police stations, courts and prisons) for his journey from the court to the prison, recorded Mr Davey had a drug overdose in 2006 and 2014.
32. Mr Davey had been referred to Avon and Wiltshire Mental Health Partnership and was diagnosed in November 2017 with borderline emotional personality disorder. He was taking anti-psychotic and anti-depression medication in the community.
33. During his pre-sentence interview, Mr Davey told a probation officer that he had tried to kill himself by a drug overdose in 2006 and 2014, that six months earlier he had planned to kill himself by drowning and that he regularly experienced suicidal thoughts and suffered from depression. He assessed that Mr Davey had to be closely monitored both in the community and in custody because he was at risk of suicide and self-harm.
34. At 5.10pm, Mr Davey arrived at Bullingdon from Swindon Crown Court. At around 6.30pm, a nurse recorded during an initial health screening that Mr Davey had a history of self-harm and noted that he was anxious and depressed. The nurse started ACCT procedures because Mr Davey told her that he wanted to self-harm. She referred him for a mental health assessment because of his history of anxiety and depression.
35. The nurse assessed that Mr Davey was suitable to hold his medication in possession although she was vague in explaining to the investigator what criteria she had applied to reach her conclusion. Mr Davey was taking citalopram (an antidepressant), risperidone (a tranquilliser), propranolol (for anxiety), cetirizine (for allergies) and asthma inhalers. The nurse assessment meant that Mr Davey could keep medication in his cell and did not have to take every dose at the wing's medication hatch under supervision.
36. An officer later assessed that Mr Davey could share a cell with another vulnerable prisoner and asked Mr Davey to complete a first night questionnaire. Mr Davey informed him that he had tried to harm himself in the past and that he had wanted to die on the last occasion. He also said that he was feeling "low in spirits". Officers located Mr Davey in F Wing, the induction unit, on a temporary basis.
37. On 2 December, a prison GP reviewed Mr Davey. He recorded that Mr Davey had been reviewed by a psychiatrist in the community and that he had been allocated a Community Psychiatric Nurse (CPN). He referred Mr Davey to the mental health team and prescribed him his medications, some to be taken 'daily in possession', such as his propranolol.

38. At 3.35pm, during his ACCT assessment, Mr Davey told an officer that he was anxious about the length of his sentence and felt remorse about his offence. An officer recorded that Mr Davey had not self-harmed for the past three months but was feeling very sad. Mr Davey repeated his previous history of self-harm and suicide attempts but said that he was not feeling suicidal. The officer told the investigator that she was aware that Mr Davey was taking medication but not what, nor any details of the dispensing arrangements.
39. At 5.05pm, two supervising officers (SOs) carried out the first ACCT case review. No healthcare staff attended. Mr Davey told the SOs that he was struggling, although it helped him to speak to his family and friends. They assessed that Mr Davey's risk of suicide and self-harm was low, and continued staff observations at once every hour. A SO completed the ACCT caremap setting out two actions to address Mr Davey's risk: one to move him to E Wing, the unit used for the treatment of sex offenders, and the other to help him find employment. Records show that Mr Davey was never employed but it was noted in the caremap that he started English and Maths courses which were intended to help him address his risk factors.
40. Medication dispensing charts show that staff dispensed Mr Davey with propranolol daily for 40 days, from 3 December 2017 until 11 January 2018 (the day of his overdose). Mr Davey received three tablets of 80 milligrams of the medication each day; one to be taken in the morning under the direct supervision of staff. Mr Davey would then take away a pouch containing two tablets for his lunch and evening doses. He kept these doses in a locked cabinet in his cell.
41. On 7 December, Mr Davey moved to E Wing. On 9 December, a SO, an officer and a nurse (attending over the phone) spoke to Mr Davey during a second ACCT case review. He told them that he still had thoughts of self-harm but no plan to act on them. He said he had been in contact with his family, had visits booked and that he was getting on well with his cellmate. The officers and the nurse decided to end Mr Davey's ACCT monitoring because he said he had no plan to kill himself, and presented well. They assessed that his risk of suicide and self-harm was low. The post-closure interview was scheduled for the 14 December but did not take place.
42. On 12 December, a nurse discussed Mr Davey's case during a mental health referral meeting. She recorded that Mr Davey's local Community Mental Health Team (CMHT) confirmed that they had worked with Mr Davey who had been diagnosed with Emotional Unstable Personality Disorder (EUPD) due to a childhood trauma. They also confirmed that Mr Davey was being managed under the Care Programme Approach (CPA) and that they were looking at referring Mr Davey for a psychological assessment. A nurse added Mr Davey to the mental health in-reach team and allocated his case to a nurse.
43. On 15 December, his allocated nurse assessed Mr Davey who was concerned that he was going to miss out on his early 20s as he had received a long sentence. She recorded that Mr Davey had had mental health issues since the age of nine and was well supported by family and friends. He said that he did not want his family to know that he had committed the offence. He said that he was going to complete his sex offender programme at the prison and move to HMP

- Erlestoke to be closer to his family. Mr Davey repeated that he had suicidal thoughts daily but had no plans to act on them. She found no evidence that Mr Davey had an enduring mental health illness. She assessed that he did not need input from a psychiatrist but planned to support him with a move to a more appropriate prison environment.
44. On 29 December, the allocated nurse reviewed Mr Davey again. He told her that he had developed a plan to kill himself – and this was something that scared him. She recounted, however, that he said this smiling). He said that he was giving himself until the end of January and “if things did not change” then he was going to kill himself. Mr Davey would not disclose his plans. She asked Mr Davey whether staff should start ACCT monitoring for him but Mr Davey said that he did not feel he had benefited from it and that he was going to remain safe. She told Mr Davey that she would support him moving to the therapeutic community available at HMP Grendon but did not start ACCT monitoring.
 45. On 4 January, the allocated nurse and Mr Davey’s offender supervisor spoke to Mr Davey on E Wing. She recorded that Mr Davey was “bright in mood”. Mr Davey said that he was keen to stop taking citalopram and risperidone because it would help him to meet the criteria for joining the therapeutic community at Grendon. (Prisoners are expected not to use psychotropic medication there.) They also discussed how Mr Davey was going to gain experience of group therapy interventions during his sexual offender programme, which was to start on 15 January. The nurse arranged to review him two weeks later and to continue monitoring him.
 46. The nurse told the investigator that she asked Mr Davey about his suicide plan. but Mr Davey said that although he still had suicidal thoughts, he no longer had a plan, and did not want to harm himself.
 47. Later that day, a prison GP discussed Mr Davey’s case with the allocated nurse. The prison GP agreed to a gradual reduction of Mr Davey’s citalopram and risperidone. Mr Davey’s citalopram was reduced from 40mg to 20mg per day, and his risperidone reduced from one milligram at breakfast and dinner to one milligram once a day. He also recorded that Mr Davey’s risk of self-harm and suicide would always be of a low to moderate level within the context of his mental health disorder. He pointed out that it could increase around the times of medication change but this could be ameliorated by monitoring of his mental state.
 48. On 7 January, Mr Davey made cuts to his left forearm with a razor. He was sad and crying. Mr Davey told an officer that he had self-harmed to ease the pain in his heart. At 1.40pm, an officer started ACCT monitoring. A custodial manager (CM) completed an immediate action plan setting staff observations at once every hour, and one conversation in the morning and one in the afternoon. A nurse also reviewed Mr Davey and dressed his cuts. She informed his allocated nurse about Mr Davey’s self-harm. Mr Davey’s nurse said that the nurse was not worried about Mr Davey and that she had just informed her out of courtesy. She therefore did not plan to review Mr Davey immediately and had no input thereafter during his ACCT monitoring.

49. At around 3.45pm, a SO carried out the ACCT assessment interview with Mr Davey. Before the assessment, the SO did not speak to healthcare staff or seek any healthcare-related information. Mr Davey told him that he was feeling down because he had received a letter from his solicitor saying that he could not appeal his sentence and that it appeared that his family had produced statements testifying against him. He said that he was not trying to kill himself and did not feel suicidal at that point but that he felt better after he self-harmed. He also said that he was waiting to join the therapeutic community at Grendon and that he had the support of his father. The SO did not know the dispensing arrangements of Mr Davey's medication but Mr Davey told him that he was working with his allocated nurse from the mental health team.
50. At 4.55pm, a CM completed the first ACCT case review with an officer. The CM recorded that Mr Davey repeated that he had received a "bad letter" from his solicitor but that he did not have any thoughts of self-harm. Officers assessed that Mr Davey risk of suicide and self-harm was low because he did not have current thoughts of self-harm. The CM did not complete a caremap.
51. The same day, Mr Davey was subject to a mandatory drug test (MDT). The results, which arrived after his death, showed the presence of cannabis. However, we found no intelligence or any other record linking Mr Davey with the prison's drug culture.
52. On 10 January, at 10.40am, a SO and an officer carried out the second ACCT case review. This was the first ACCT review the SO had chaired and she had received no case management training. Although the SO knew that Mr Davey had a mental disorder and was working with a mental health nurse, she did not consider inviting anybody from the healthcare team because she said that it was not usual practice to do so. She did not know that Mr Davey was taking medication either. The officers assessed that Mr Davey was a low risk for suicide and self-harm because he was talking about getting a job, helping prisoners when they left prison, and had positive plans for the future. The SO decided to end the ACCT monitoring and completed the ACCT caremap recording two issues: the solicitor's letter and the fact that Mr Davey had "too much time to think".
53. At around 3.55pm, Mr Davey had the first individual session of his sex offender programme. He told a trainee psychologist that he was feeling slightly anxious about starting the programme. She told the investigator that she was aware Mr Davey had only just come off an ACCT document so she monitored his general appearance and demeanour closely. She said that although Mr Davey appeared shameful about his offending, this was no more than usual for an individual about to undertake an offending behaviour programme. He was jovial throughout the session. Once the session concluded, as a precaution, she phoned the wing and asked an officer (she did not remember or record the name) to be aware of Mr Davey's varied emotions and to keep an eye on him. She recorded her interaction in NOMIS including that she had spoken to staff to request that they check on Mr Davey but officers made no record of this in the wing's observation book.

11 and 12 January

54. On 11 January, at around 5pm, Mr Davey and his cellmate were locked in their cell. His cellmate said that he started to watch TV. He was seated on a chair while Mr Davey was lying on his bed facing the wall. (The cellmate had been allocated the top bunk while Mr Davey had the bottom bunk). Mr Davey then sat down and started to smoke an e-cigarette. The cellmate said that he tried to speak to him but Mr Davey did not want to talk. Mr Davey then began writing a letter.
55. At around 8.46pm, an officer started working in the control room, checking the radio net and controlling the radio traffic. Around 30 minutes later, a CM asked the officer to go to the gatehouse, which is situated on the floor below the control room, to open the gate to allow officers entry to the prison. There were no other staff available to do this. The officer left the control room and moved to the gate. The control room was left unattended until around 10.21pm.
56. At around 10.00pm, Mr Davey's cellmate saw him suddenly "jumping up" into a sitting position and begin to vomit. He helped Mr Davey move close to the sink, then sat him on the floor with his head on the bed. He then pressed the cell bell. He said that within a couple of minutes, an OSG attended and opened the observation panel. (We have not been able to confirm timings as Bullingdon does not have an electronic system to record bells. Nor is there CCTV on E Wing.) Mr Davey's cellmate told the OSG that Mr Davey needed help as he was sick. The OSG saw that Mr Davey was vomiting in the sink, went back to the office and at around 10.10pm phoned a CM and a nurse. The nurse advised her that there was not much she could do and asked her to keep an eye on Mr Davey.
57. The OSG said that around five minutes after attending Mr Davey's cell, she heard the cell bell again. She went and looked through the hatch and saw that Mr Davey appeared to be fitting. She immediately called a code blue emergency over the radio. (This indicates that a prisoner is unconscious or having difficulty breathing.)
58. An officer was still at the gate and could not hear the code blue call on his radio clearly due to the noise in the area. He said that about a minute or two later, he went back to the communications room to replay the radio transmission and heard the code blue then. The officer recorded in the control room log the time the system logged the initial radio call. This was at 10.19pm. After re-hearing the code blue, the officer did not call an ambulance.
59. The CM and two nurses attended Mr Davey's cell and the CM opened the door. Three officers also attended. A nurse told police that when she arrived in the cell, Mr Davey was lying on the floor with his head supported by a pillow. She noted that he had been vomiting. She told the police that Mr Davey was conscious but his body was shaking. He was able to sit down and, initially, was able to talk coherently.
60. Mr Davey told the nurse that he had been "saving" his prescribed medication and that he had taken an overdose of 63 tablets of propranolol at around 8.30pm. Mr Davey showed them the empty packets and pointed towards a lockable cabinet

in his cell. At around 10.31pm, the nurse asked the CM to request an ambulance immediately, which he did. While they waited for the ambulance to arrive, she also asked the other nurse to call 'Toxic Base', a national help-line which provides information and advice on overdose cases. The help-line advised the nurses to send Mr Davey to hospital immediately.

61. Ambulance records show that an officer called the ambulance at 10.34pm. The nurse recorded that Mr Davey started to have intermittent violent body spasms. She told the police that as the incident progressed, Mr Davey remained conscious although sometimes his voice became weak and he spoke incoherently.
62. According to ambulance service records, the ambulance arrived at the prison gate at 10.50pm and paramedics arrived at Mr Davey's cell at 11.00pm. At 11.08pm, Mr Davey suffered a further seizure and at 11.09pm went into a cardiac arrest. Paramedics started cardiopulmonary resuscitation (CPR) which they continued when they moved Mr Davey to an ambulance. At 11.49pm, the ambulance left the prison and Mr Davey was transferred to the hospital where he arrived at 12.11am on 12 January. At 12.31am, a doctor pronounced him dead.

Contact with Mr Davey's family

63. On 11 January, at around 11.50pm, a prison manager phoned Mr Davey's father and told him that Mr Davey had been taken to hospital as he was unwell.
64. On 12 January, at 1.20am, the prison manager appointed an officer as the family liaison officer (FLO). At 2.50am, she attended hospital with an officer and together with the hospital consultant and a nurse, delivered the news of Mr Davey's death to his father. The FLO continued contact with Mr Davey's father and offered support thereafter. On 25 January, she visited Mr Davey's family home. Mr Davey's funeral took place on 1 February and the prison contributed to the funeral costs in line with national policy.

Support for prisoners and staff

65. After Mr Davey'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.
66. The prison posted notices informing other prisoners of Mr Davey'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 Mr Davey's death.

Toxicology and Post-mortem reports

67. The pathologist concluded that Mr Davey died of "aspiration of gastric contents" and propranolol intoxication. The pathologist said that it is likely that the propranolol intoxication had caused Mr Davey's seizures and induced him to vomit. This posed a threat to the airway, leading to aspiration of gastric contents, (inhaling his vomit), into his respiratory system.
68. The toxicology report found that Mr Davey had a concentration of propranolol which was much higher than would be expected following the use of therapeutic

amounts. This concentration might have been considerably higher at the time Mr Davey was first found in his cell. Broadly therapeutic concentrations of citalopram and risperidone were also found. No alcohol or psychoactive substances were detected.

Discovery after Mr Davey's death

69. Following Mr Davey's death, police officers found empty packets of propranolol, unused propranolol and cetirizine in his cell. They also found two suicide letters (one incomplete) addressed to his family where he expressed remorse for his offence and asked them to forgive him for his actions.

Findings

Clinical Care

70. The clinical reviewer found that Mr Davey's old GP records were accessed promptly and mental health referrals were acted on swiftly. Although Mr Davey's CPA was not continued at the prison, he had the support of a nurse who was his named key worker and a psychiatrist who defined a care plan for Mr Davey. The clinical reviewer, however, was concerned that healthcare staff neither properly reviewed Mr Davey's dose of propranolol at Bullingdon nor sufficiently monitored his mental health following changes in his medication. The clinical reviewer concluded that the healthcare provided to Mr Davey fell below the level of care he could have expected to receive in the community.
71. The clinical reviewer pointed out that the British National Formulary, which is the national prescribing authority, lists that the maximum amount of propranolol to be prescribed to a patient for anxiety should be 40mg, taken three times daily. He said that although Mr Davey's prescription of 80mg of propranolol was not in itself harmful this dose should have been reviewed.
72. On 4 January 2018, the psychiatrist reduced Mr Davey's dose of citalopram and risperidone because Mr Davey wanted to go to Grendon to join its therapeutic community. Records show that Mr Davey then missed doses of citalopram over the following two days but the clinical reviewer has found no clear explanation for this. The clinical reviewer said that the reductions, and the two missed doses, may have had an impact on Mr Davey's mental state.
73. The psychiatrist was vague about when Mr Davey's medication should have been reviewed but he recorded that "named key worker was going to see him during the week to monitor mood and mental state before any further reduction". No healthcare staff reviewed Mr Davey's medication following his input. We make the following recommendation:

The Head of Healthcare should ensure that staff clearly record the reasons for prescribing higher doses of medication than advised in national guidelines and that an effective system is put in place for healthcare staff to review and monitor a prisoner's mental health, following any changes in his medication.

Assessment of risk of holding medication in-possession

74. The Head of Healthcare, told the investigator that at Bullingdon, prescribed medication can be dispensed in three ways:
- 1- Not in possession – where the prisoner attends the medication hatch and a nurse or a pharmacy technician gives him the medication. The nurse supervises and ensures the prisoner consumes the medication.
 - 2- Daily in possession – the prisoner attends the medication hatch to collect his medication. He will take some medication away in a labelled pouch for later use but will consume some of the medication under supervision.

- 3- In possession – this is how medication is dispensed to patients in the community. The prisoner picks up his medication from the hatch. Medication is given to cover a period of prescription, ie. 7, 14 or 28 days. Prisoners keep the medication in a lockable cabinet in their cells.

75. On 1 December, a nurse assessed that Mr Davey could have his propranolol in possession, among other medication. The Head of Healthcare told the investigator that the method of assessing the risk of prescribing medication in possession to prisoners was updated over the weekend of 2-3 December 2017. This was just after Mr Davey arrived at Bullingdon. The new method applies a more robust and structured numerical scoring system. It expressly points out that the assessment may be reviewed when a prisoner has been placed on ACCT monitoring. The method that a nurse used relied largely on her judgement but she could not explain to the investigator how she reached her conclusion, nor could she provide specific details or evidence supporting her assessment.
76. Given Mr Davey's background and risk factors for suicide and self-harm on his arrival at Bullingdon, it is hard to understand how a nurse assessed him as suitable to have his medication in possession. She knew his history of self-harm and noted that he was anxious and depressed on arrival. Mr Davey also told her that he wanted to self-harm. We believe that it was inappropriate and ill-advised in the circumstances, to assume that Mr Davey was not going to consider using his medication to harm himself.
77. It is also regrettable that a nurses in-possession risk assessment was the only assessment that healthcare staff carried out on Mr Davey while he was at Bullingdon, not least given that a new and more rigorous process was adopted immediately after his arrival. We agree with the clinical reviewer that staff missed opportunities to use the new method to re-consider his circumstances. We make the following recommendation:

The Head of Healthcare and Prison Pharmacy should ensure staff regularly update risk assessments for prisoners holding in-possession medication and trigger ad hoc updates, particularly when an ACCT document is open.

ACCT Management and Assessment of risk

78. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, provides a non-exhaustive list of a number of risk factors and potential triggers that might increase a prisoner's risk of suicide and self-harm. These require staff to take appropriate action, including starting ACCT procedures, if necessary. These risk factors were also listed in our thematic report published in 2014.
79. Mr Davey presented at Bullingdon with many risk factors for suicide and self-harm, including the nature of his offence, this being his first time in custody, and a history of suicide attempts and self-harm. In addition, Mr Davey had expressed worries about the length of his sentence and had made statements that he was self-harming as a coping mechanism for his feelings of remorse about his offence. He also told his key worker in December that he had a plan to kill himself, although did not disclose what this was. Mr Davey had been involved with mental health services both in the community and in prison and suffered from a

personality disorder, which carried a further risk of impulsive, self-harming and suicidal behaviour.

Assessment of risk and closure of ACCTs

80. In April 2014, we published a Learning Lessons Bulletin on 'Risk Factors in Self-Inflicted Deaths in Prison'. We identified that staff often place too much weight on how a prisoner presents, rather than on existing risk factors. The bulletin highlighted that prisoners will often withhold the extent of their distress from staff, and evidence of risk should be fully balanced against how the prisoner presents.
81. Although we recognise that Mr Davey was making tangible plans to move forward and engaged in treatment pathways, we believe that it was premature for staff to have stopped monitoring and offering support through the ACCT process, given his background and risk factors. On 9 December, a SO, two officers and a nurse concluded Mr Davey's first period of ACCT monitoring notwithstanding that Mr Davey told them that he was still thinking of self-harming.
82. The post-closure review arranged for 14 December never took place as the SO was off work through illness but nobody followed up in his absence. PSI 64/2011, *Safer Custody*, and the prison's local suicide and self-harm policy, both highlight the importance of the post-closure stage and state that at the post-closure interview, staff must review the caremap and any progress made by the prisoner since the ACCT was closed. Staff therefore missed an opportunity to re-assess Mr Davey's risk and, crucially, to review his support plan on this occasion.
83. We are also concerned about the key worker's assessment of Mr Davey's risk of suicide and self-harm after 29 December 2017, when Mr Davey told her that he had a plan to kill himself and that he was going to give himself until January before acting on it. Although she said that Mr Davey would not share any details of his plan, she relied heavily on his presentation to assess that he was at low risk of suicide. The ACCT's suicide and self-harm risk guidance states that a prisoner is to be considered at 'raised' or 'high risk' of suicide and self-harm when he has frequent suicidal ideas, has a plan (specific or otherwise) to kill himself, has made previous suicide attempts, and has self-harming behaviour and mental health issues. We believe that the nurse did not give the appropriate importance to such statements and should have opened an ACCT, or at least inform staff on the wing about Mr Davey's comments.
84. An officer told the investigator that at the case review held on 10 January, a SO assessed that Mr Davey was fine but sought her opinion. The SO told the investigator that she was inexperienced at chairing ACCT reviews and therefore relied on an officer to lead and make decisions. The officer said that she considered that Mr Davey was not benefiting from the ACCT monitoring because he presented well and he was happy for the ACCT to be closed. The officers did not consider the consequences of closing the ACCT nor the fact that Mr Davey would be left unsupervised and unsupported. The SO and officer wrongly over-relied on Mr Davey's presentation to assess his risk.

Caremaps

85. PSI 64/2011 requires caremaps to be completed during the first ACCT case reviews and to reflect the prisoner's needs, level of risk and their triggers of distress. They should aim to address issues identified in the ACCT assessment interview. They must be tailored to meet prisoners' individual needs and reduce risk. They must be time-bound and state who is responsible for completing the action. They should also be updated following every case review. Caremaps are fundamental in identifying key actions and set out a strategy to support prisoners at risk of suicide and self-harm.
86. The CM did not complete a caremap for Mr Davey during his first ACCT case review on 7 January. He said that he had overlooked this because he did not have much experience in managing ACCT documents and had not received training. Three days later, the SO who carried out the second ACCT case review tried to amend the oversight and completed a caremap but as she decided with another SO to close the ACCT on that day, this came too late.
87. Bullingdon's Local Operation Procedure 07 – *Prisoners at Risk of Suicide and Self-harm*, recognises the importance of family initiatives including their involvement during any ACCT review process. At no point did staff give any consideration to involving Mr Davey's father in the ACCT process, even though Mr Davey often said his father was providing him with valuable support.
88. The same local policy points out that ACCT case managers should recognise the risk from any in-possession medication the prisoner might be holding and consider ways to minimise this risk. The staff involved in Mr Davey's ACCT monitoring did not address this issue and so no actions were taken or planned. Because of the lack of effective communication with healthcare staff, officers on the wing were largely unaware that Mr Davey was taking medication or of his dispensing arrangements.

ACCT reviews

89. PSI 64/2011 stipulates that case reviews should be multidisciplinary if possible. Bullingdon's local policy stipulates that the ACCT case review will bring together the person at risk and the team involved in their care to review progress. During Mr Davey's second ACCT monitoring period, no member of the mental health team participated in the ACCT reviews. A CM, a SO and an officer did not request healthcare attendance at the review on 10 January or contact his nurse, who was a key person involved in Mr Davey's care. The officer told the investigator that at the time of Mr Davey's death, it was not routine to invite healthcare staff to case reviews and that usually staff would have invited "whoever they could grab".
90. Mr Davey's nurse told the investigator that the mental health team rely largely on officers contacting them to know that a case review is going to take place. But we found that staff are not always aware that a prisoner is under the care of the mental health team and therefore do not consider issuing an invitation. She said that healthcare staff are now starting to make entries in NOMIS, recording when a prisoner is working with them so that such information is available to staff.

However, we found no such entries in relation to Mr Davey, or any notes made by any member of staff about Mr Davey in the wing's observation book.

91. She also said that although there is a shared calendar containing dates of the ACCT reviews which they could consult, the calendar is not always checked.
92. Although we appreciate that some ACCT case reviews took place during weekends when the mental health nurses were off duty, arrangements should have been made for better input from his nurse into Mr Davey's ACCT process.
93. An officer told the investigator that before she attended the last ACCT case review on 10 January, she did not check any risk-pertinent information related to Mr Davey, including the ACCT document itself or previous ACCT reviews. She said that it did not occur to her that it was necessary. This shows poor case review planning which is key to deliver a successful outcome, as acknowledged in the prison's local suicide and self-harm policy. Checking the ACCT document would have meant an officer would have been aware that Mr Davey was under the care of the mental health team and had a better understanding of his background, risk factors and the state of the actions that were supporting him.

Information sharing

94. In our thematic review of learning from PPO Investigations on mental health, published in January 2016, we said that it is vital that relevant information is communicated to prison staff when mental health problems are identified by healthcare staff, so that they are as informed as they can be about a prisoner's need and can play a part in providing support. When prison staff are well informed about a prisoner's mental health issues, this can help them to relate to that prisoner's behaviour, to recognise distress and to respond in the most appropriate manner to support that prisoner.
95. During the second period of ACCT monitoring there was poor information sharing between healthcare staff and discipline staff. The ACCT assessment interview guidance clearly sets out that before an interview, staff should gather risk-pertinent information including asking healthcare staff if they are aware of risk factors such as recent psychiatric treatment.
96. The CM who carried out Mr Davey's ACCT assessment interview on 7 January 2018, and the officer who carried out Mr Davey's ACCT review on 10 January, told the investigator that they did not know that Mr Davey held medication in-possession. Nor were they aware of the nature of his mental health problems because they did not consult healthcare staff about Mr Davey's medical background, medication or records. The CM said that before an ACCT assessment he would generally take prisoners at face value.
97. We also have concerns about healthcare staff not sharing relevant information with discipline staff about Mr Davey's mental health issues, medication dispensing arrangements or the possible consequences of not taking his medication, such as low mood or suicidal or self-harming feelings.
98. The lack of knowledge of discipline staff about Mr Davey's mental health issues and medication, and lack of consideration of risk-pertinent information meant opportunities were missed to assess his risk during case reviews.

Conclusions about ACCT procedures

99. Staff judgement is fundamental in operating ACCT procedures. The system relies on staff using their experience and skills, as well as on local and national assessment tools to determine risk. We recognise that that both discipline and mental health staff offered support to Mr Davey throughout his time at Bullingdon, including the provision of a supportive environment on E wing. We are nevertheless concerned that staff gave undue weight to Mr Davey's presentation rather than to his overall welfare needs and the broader factors indicating his risk of suicide and self-harm.
100. Staff should have considered all of those risk factors to ensure that his level of risk was judged holistically. Failure to do so meant that they did not identify or put in place effective actions to increase his protective factors in the days leading up to his death. We consider that better suicide and self-harm management might have changed the outcome for Mr Davey. We are concerned to find that many staff with key roles within the ACCT process, such as a SO and CM, had not received adequate ACCT training.
101. We are concerned that we have already made similar findings in our investigations into the deaths of two prisoners previously at HMP Bullingdon. The prison needs to take more robust action. We make the following recommendation:

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

- **identify all the known risk factors of a prisoner and share information to provide collaborative care and treatment, in particular ensuring effective joint working between healthcare and prison staff when there are concerns about a prisoner's mental health;**
- **assess a prisoner's risk considering his circumstances and risk factors and not just his personal presentation;**
- **ensure a trained ACCT assessor use all relevant information to complete the ACCT assessment, including consulting with healthcare staff;**
- **complete caremaps at the first ACCT case review which must be appropriately updated thereafter, setting out specific and meaningful actions, including inviting the family where appropriate, identifying who is responsible for actions and reviewing progress at each review;**
- **conduct ACCT post-closure interviews as specified in the national instructions and local policy; and**
- **undertake relevant training which is regularly updated.**

Emergency response

102. PSI 03/2013, *Medical Emergency Response Codes*, contains mandatory instructions for efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that it should not be a requirement for a member of the healthcare team or a manager to attend the scene before an ambulance is called.
103. The officer covering the control room did not call an ambulance immediately after an OSG called the code blue emergency on 11 January because, initially, he was unable to hear the radio message clearly because he was at the gatehouse not the control room. Due to staff shortages on 11 January, because of an earlier emergency escort out of the establishment, an officer had been given responsibility for both the control room and the gatehouse, immediately below. The control room was unattended for more than an hour, from around 9.16pm to around 10.21pm.
104. Once an officer returned to the control room and had listened to the radio recording of the code blue, he still did not call an ambulance immediately because he believed he needed to check with wing staff that it was still required. When he did so, after 10.21pm, he asked the CM over the radio but the CM did not confirm. It was only when Mr Davey began fitting that an officer called the ambulance. As a result, according to the ambulance records, there was a delay of about 15 minutes in calling the ambulance.
105. There was a further delay of approximately 10 minutes in paramedics reaching Mr Davey's cell from the gate. An officer told the investigator that this was because he had to manage automatic gate locks and arrange escort of the vehicles while covering both gate and control room duties. This is not the first time that we have found ambulance access to the prison during emergencies to be unnecessarily delayed. The prison need to address this issue with urgency.
106. Although the clinical reviewer could not confirm whether this delay impacted the outcome for Mr Davey, in other cases it could be crucial. We make the following recommendations:

The Governor should:

- **review arrangements for emergency vehicles' access to the prison to reduce avoidable delays; and**
- **ensure that all prison and healthcare staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies as outlined in the local Medical Emergency Response Code Protocol so that there is no delay in calling, directing, discharging or allowing access to ambulances in to the prison.**

Previous PPO recommendations and prison actions

107. In our investigations into the deaths of prisoners in July 2016 and in December 2017 at HMP Bullingdon, we found that staff poorly assessed the prisoner's risk

of suicide and self-harm and as a result no appropriate actions were taken. We made recommendations to address this and the prison said they would issue notices to remind staff of their responsibilities and provide further training. The similarities between these deaths and that of Mr Davey suggest that more sustained and effective action is required from the prison to address our concerns.

108. In the investigation into the death of Mr Wright, we found that ambulance access during the emergency response was delayed due to a technical problem with the gate and we made a recommendation. The prison responded that emergency vehicle access would be included in the establishment's contingency plans and would be regularly tested.
109. Although we accept that there was insufficient time for the prison to have implemented changes in the interval between Mr Wright's and Mr Davey's deaths, the fact that this investigation has found further deficits in the procedures for emergency access demonstrates that the prison still has more work to do in order to ensure prompt access to the prison for emergency vehicles.
110. In light of the troubling similarities between these investigations, we make the following recommendation:

The Prison Group Director for the South Central Group should assure himself that meaningful action is taken to address our recommendations.

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