Report of an Investigation under Article 2 of the European Convention of Human Rights into the circumstances surrounding the life-threatening self-harm of Mr Everest at HM Prison Altcourse on February 22nd 2014

Final Report

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Glossary

Addaction	a third sector organisation providing substance misuse services
amisulpride	an antipsychotic medication
amitriptyline	an antidepressant medication
anhedonia	the reduced ability to experience pleasure
anoxic	a total depletion in the level of oxygen in the blood
ataxia [as in limb ataxia]	a neurological syndrome characterised by clumsy and uncoordinated movement of the limbs
BP	Blood Pressure
cannula	a thin tube inserted into a vein or body cavity to administer medication, drain off fluid, or insert a surgical instrument
CARATs	Care, Assessment, Referral, Advice and Through-Care services. An external agency providing services for people with alcohol and drug problems
Category B [as in Category B prison]	The category of prisoners who do not require maximum security, but for whom escape would still pose a large risk to members of the community.
Category D [as in Category D prison]	The category of prisoners who can be reasonably trusted not to try to escape, and are given the privilege of an open prison.
CBT	Cognitive Behavioural Therapy, a type of talking treatment
citalopram	an antidepressant medication
CMHT	Community Mental Health Team
co-codamol	a type of analgesic medication (pain relief)
Code one (code blue)	a radio alert for staff for emergency response in cases of chest pain, difficulty breathing, loss of consciousness, choking, fit, severe allergic reaction or suspected stroke

Code red	a radio alert for staff for emergency response. Should be used for blood, burns and fractures.
cognition	refers to thinking and conscious mental processes
community health and/or substance misuse facility 1	a third sector provider of substance misuse services in the community
community health and/or substance misuse facility 2	an NHS Community Mental Health Team facility in city 1
community health and/or substance misuse facility 3	a specialist neurorehabilitation centre for people with acquired brain injury and complex needs. It is in city 1.
constant observation	observation without a break
constant watch	as constant observation above
CPR	cardiopulmonary resuscitation. The administration of life-saving measures to a person who has suffered a cardiac arrest. A person in cardiac arrest is not breathing and has no detectable pulse or heartbeat.
CT scan	Computerised Tomography scan (used as a brain scan)
dysarthric speech	a disorder involving slurring of speech
disposal	outcome in a court hearing
diurnal variation (of mood)	change in the intensity of low mood, worse in the mornings
DLA	Disability Living Allowance
DNR	Do Not Resuscitate
endocrine	refers to the hormonal system of the body
endogenous depression	a type of depression without an external cause
Epilim	a type of medication used to stabilise mood and also in epilepsy

extubate	to remove a tube used to assist respiration
Fish knife	a commercially-produced knife that can be used as an anti-ligature 'cut-down' tool
formulation	a systematic and precise statement of a problem, with exploration and explanation of components of the problem
Glasgow Coma Score	This is the most common scoring system used to describe the level of consciousness in a person following a traumatic brain injury.
HM Prison and Probation Service	On 1st April 2017 Her Majesty's Prison and Probation Service (HMPPS) replaced the National Offender Management Service (NOMS) as the Executive Agency responsible for delivering prison and probation services in England and Wales.
Hospital 4	a hospital in city 1 with specialist neurology facilities. It is part of the county 1 and county 2 Rehabilitation Network. Hospital 4 includes a Hyper-Acute Unit.
hyperprolactinemia	high levels of the hormone Prolactin, due to medication in this case
hypoxic	lacking in oxygen (e.g. to the brain)
IEP	Incentives and Earned Privileges scheme Basic Level is for those prisoners who have demonstrated insufficient commitment to rehabilitation and purposeful activity, or behaved badly and/or who have not engaged sufficiently with the regime to earn privileges at a higher level. Entry Level. All new prisoners, including those on remand, newly convicted or recalled to prison will enter custody on the 'Entry' level.

	Standard Level is for all prisoners who have successfully completed the 'Entry' level requirements and those who are considered to be meeting rehabilitation expectations, participating in the regime and behaving well. Enhanced Level is reserved for those prisoners who have demonstrated, for a minimum period of three months, that they are fully committed to their rehabilitation.
ischaemic	lack of blood to an organ
ITU	Intensive Treatment Unit
kit car course	a training course to make motor vehicles from kits
'legal highs'	See entry for NPS.
levetiracetam	a medication used to treat epilepsy.
MDT	Multi Disciplinary Team
mirtazapine	an antidepressant drug
myoclonic	a brief, involuntary twitching of a muscle or a group of muscles
NPS	new psychoactive substances. NPS contain one or more chemical substances which produce similar effects to illegal drugs (such as cocaine, cannabis and ecstasy). NPS are often incorrectly called 'legal highs'.
NRU	neuro-rehabilitation unit
OMU	Offender Management Unit
pancreatitis	inflammation of the pancreas
PANNS	positive and negative symptoms scale for schizophrenia assessment
paranoid	an irrational distrust of others or fear
PCMHT	Primary Care Mental Health Team

PCO	Prison Custody Officer
peer supporter	a generic term which includes Listeners and carers. Listeners are prisoners trained by the Samaritans to provide support to other prisoners. However, the Samaritans do not support a Listener scheme at HMP Altcourse. Altcourse has a carers scheme. Training is not provided by Samaritans.
PEG feed	Percutaneous endoscopic gastrostomy (PEG) is an endoscopic medical procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate.
personality disorder	a mental disorder characterised by life-long difficulties in multiple areas
PHQ	Primary Health Questionnaire
PNC	Police National Computer
propranolol	a type of medication, a beta blocker, used to treat high blood pressure and anxiety
psychosis	A series of symptoms in which the individual loses contact with reality. The symptoms may include hearing voices and/or having delusions (abnormal beliefs).
quetiapine	an anti-psychotic medication
RCGP	Royal College General Practitioners
RMN	Registered Mental Nurse
safer cell	a cell which has had potential ligature points removed
SATS	level of oxygen saturation in the blood
schizophrenia	a mental disorder characterised by hallucinations (hearing voices) and delusions (abnormal beliefs)
sertraline	an antidepressant drug
skunk	a potent form of cannabis
sleep hygiene	simple strategies to improve sleep patterns

sodium valproate	medication used as a mood stabiliser or to treat epilepsy
The Specialised Rehabilitation Unit at Hospital 3	a specialist rehabilitation unit caring for patients who have experienced severe, life-changing injury or illness. It is at Hospital 3, county 2.
spliff	a cigarette containing the drug cannabis
SSRI	Selective Serotonin Re-uptake Inhibitor. A group of antidepressants
SystmOne	SystmOne provides clinicians and health professionals with a single shared Electronic Health Record (EHR) available in real time at the point of care.
Talking Therapies	a treatment involving talking. Includes, for example, Cognitive Behavioural Therapy
titration (or 'to titrate')	to gradually increase the dose of a drug whilst monitoring the effect and any side effects
triage	prioritisation of patients for medical treatment
TWOC	Taken Without Owner's Consent, an offence under the Theft Act 1968
Zopiclone	a sleeping tablet

CONTENTS

Glossary

Chapter 1 Structure of the Report 11

Chapter 2 The Investigation 13

Commissioning 13

Methods used in the Independent Investigation, 2015 – 2017 14

The Context of Mr Everest's life-threatening self-harm at HMP Altcourse 16

Chapter 3 Care of Mr Everest in HMP Altcourse 19

Background history 19

Mental health history from records 24

Reception into HMP Altcourse, Liverpool, December 2013, to life-threatening self-harm February 2014 37

Chapter 4 The events leading up to the incident of life-threatening self-harm on 22nd February 2014 53

Chapter 5 Post-incident records 64

Prison Healthcare entries 64

Medical entries, hospital and community 65

Chapter 6 Themes from interviews with staff and family 70

Factual issues from staff interviews regarding care of Mr Everest 70

Themes regarding care provision from staff interviews 78

Information from Mrs Fuji, Mr Everest's mother 80

Chapter 7 Critical Appraisal and Findings and Recommendations 83

What was the diagnosis? 83

Care Pathway 85

Assessment of risk of self-harm 91

Emergency medical response 95

Communication and consultation with relatives 95

Information and Documentation 96

Internal assessment, the aftermath and de-brief 98

Injury 99

Public Scrutiny 99

Recommendations 100

List of Annexes ………………………………………………….

Annex 1 Copy of Core Record

Annex 2 Prison Medical Records

Annex 3 HMP Altcourse Violence Reduction Strategy. January 2015

HMP Altcourse Safer Custody Strategy. November 2015

Annex 4 Transcripts of Interviews and the Statements of Mrs Fuji

Annex 5 Security Intelligence Reports

Annex 6 Other documents reviewed but not disclosed

References

Chapter 1 Structure of the Report

This report describes an independent investigation into the circumstances surrounding the life-threatening self-harm of Mr Everest at HM Prison Altcourse on 22nd February 2014, to meet the State's investigative obligations under Article 2 of the European Convention of Human Rights (ECHR).

The report has been compiled by the Independent Investigator, Professor Jennifer Shaw. Professor Shaw received expert input on prison regime and management from Mr Andrew Barber.

The report is structured as follows:

Chapter 2. The Investigation

This chapter outlines the commissioning of the Investigation and its Terms of Reference. It also describes how the Investigation was conducted, which documents were available for examination, information obtained from the documents and information obtained from interviews. It makes it clear how the evidence relating to Mr Everest, and events surrounding his life-threatening self-harm have been obtained.

The context of Mr Everest's life-threatening self-harm at HMP Altcourse is included in detail. Since the Terms of Reference required that events leading up to Mr Everest's life-threatening self-harm should be examined in the light of policies and practices in 2014, it is important to describe the prison as it was then. This context is based on independent evidence at the time, derived from inspections conducted by HM Chief Inspector of Prisons and other documents and from interviews with staff, who were employed at that time.

Chapter 3. Care of Mr Everest in HMP Altcourse

In this chapter we describe the care of Mr Everest, including his background. We describe information on Mr Everest himself and what was known of him prior to his imprisonment in December 2013. This information is derived from a number of sources, including prison, probation and health records and our interview with Mr Everest's mother. Unfortunately, no background history was available from Mr Everest. His General Practice notes from the community are summarised, together with information from medical records from his previous prison terms.

We also document the chronology of events following Mr Everest's reception into prison in December 2013 until his life-threatening self-harm on 22nd February 2014. This includes information extracted from prison discipline and healthcare records, regarding his management and clinical care in prison, and information obtained from witness statements and from interviews with staff. We also reviewed probation records.

Chapter 4. The events leading up to the incident of life-threatening self-harm on 22nd February 2014

This chapter includes information on events of the morning leading up to the life-threatening self-harm. Information was obtained from staff statements and prison records. We describe the discovery of Mr Everest, after his life-threatening self-harm; staff efforts to revive Mr Everest; and the arrival of emergency services.

Chapter 5. Post-incident records

This chapter covers the period of time after Mr Everest's life-threatening self-harm until his eventual discharge from prison custody. The care of Mr Everest after his life-threatening self-harm was examined utilising the prison and clinical records and staff interviews. His Conditional Release Date was 20/10/2014 and his Licence expired 04/09/2015.

Chapter 6. Themes from Interviews with staff and family

The main themes coming from the interviews are summarised. Details of occurrences on specific dates are included within sections 2, 3 and 4.

Chapter 7. Critical Appraisal of the Evidence and Findings and Recommendations

In this chapter each aspect of Mr Everest's care is reviewed with reference to national and local policies, with an assessment of healthcare arrangements.

Conclusions were drawn and recommendations made on the basis of the above information.

Following my investigation into all the circumstances of this case, I provide my opinion on an appropriate level of public scrutiny.

Chapter 2 The Investigation

Commissioning

This Independent Investigation, to meet the State's investigative obligations under Article 2 of the European Convention of Human Rights (ECHR), was commissioned by the Secretary of State for Justice on 22 October 2015. The Investigation was conducted by Professor Jennifer Shaw, as Lead Investigator, with the support of Andrew Barber.

Terms of Reference

The terms of reference for the independent investigation were:

- to examine the management of Mr Everest by HMP Altcourse from the date of his reception on 6 December 2013 until the date of his life-threatening self-harm on 22 February 2014, and in light of the policies and procedures applicable to Mr Everest at the relevant time;
- to examine relevant health issues during the period spent in custody at HMP Altcourse from 6 December 2013 until 22 February 2014, including mental health assessments and Mr Everest's clinical care up to the point of his life-threatening self-harm on 22 February 2014; (see below at paragraph 26).
- to consider, within the operational context of the Prison Service, what lessons in respect of current policies and procedures can usefully be learned and to make recommendations as to how such policies and procedures might be improved;
- to provide a draft and final report of your findings including the relevant supporting documents as annexes;
- to provide your views, as part of your draft report, on what you consider to be an appropriate element of public scrutiny (see paragraph 22 below) in all the circumstances of this case. The Secretary of State will take your views into account and consider any recommendation made on this point when deciding what steps will be necessary to satisfy this aspect of the investigative obligation under Article 2 of the ECHR.

Methods used in the Independent Investigation, 2015 – 2017

We visited HMP Altcourse on five occasions, visiting relevant parts of the establishment, examining documentation, and interviewing staff involved in Mr Everest's care. We also interviewed Mr Everest's mother at her home address and spoke to Mr Everest who was also present on the same occasion. We interviewed one member of staff at another prison establishment, one at home and one over the telephone. We were able to interview all of the people whom we felt were pertinent to the investigation.

Copies of policy and process documents were provided by HM Prison and Probation Service.

Photocopies of the core Prison Service record (F2050) for Mr Everest were available to the investigators.

Photocopies of the medical records for Mr Everest, both from the community GP practice and the prison, were available to the investigators.

Copies of Probation records were provided which were examined by Professor Shaw.

The following witnesses were interviewed. Each of these interviews was tape-recorded and the transcript of it was signed by the witness, except in the cases of Miss Lupin, RMN; Miss Severn, PCO; and Miss Daffodil, RMN. Miss Lupin, RMN, advised that she had returned two consecutive signed transcripts and we concluded that reasonable efforts had been made to obtain these, but to no avail. We made several attempts to obtain signed transcripts from Miss Severn, PCO, but without success. We have received Miss Daffodil RMN's transcript but it is not signed.

Witness	Date of interview
Healthcare staff	
Dr Tulip	4th May 2016
Miss Daffodil, RMN	4th May 2016
Miss Daisy, RMN	3rd August 2016

Miss Iris, RGN	3rd August 2016
Miss Lupin, RMN	1st June 2016
Miss Poppy, RMN	15th June 2016

In addition, Professor Shaw conducted a telephone interview with the following witness and prepared a note of it.

Miss Rose, RMN	5th August 2016

Prison staff

Mr Trent	4th May 2016
Mr Ribble	5th May 2016
Miss Severn, PCO	1st June 2016
Miss Avon	5th May 2016
Mr Tyne	4th May 2016
Mr Lune, PCO	5th May 2016
Miss Thames, PCO	4th May 2016

Other professionals at HMP Altcourse

Mr Ash	1st June 2016
Mr Beech	5th May 2016
Miss Fir	4th May 2016
Miss Oak	14th June 2016
Mr Elm	4th May 2016
Mrs Fuji	5th May 2016

Mr Everest was present when we interviewed Mrs Fuji and we spoke briefly to him.

The Context of Mr Everest's life-threatening self-harm at HMP Altcourse

The terms of reference require that the management and clinical care of Mr Everest is examined in the light of policies and practices applicable at the relevant time in 2013/2014. We used independent documentary evidence available in relation to this period, supplemented by information from staff interviews.

<u>HMP Altcourse</u>

HMP Altcourse is a Category B local prison receiving sentenced and remand young offender and adult male prisoners from the courts in Merseyside, Cheshire and North Wales. The prison can accommodate 1,324 prisoners. It is located on the outskirts of Liverpool.

HMP Altcourse was the first designed, constructed, managed and financed private prison in the United Kingdom. The prison opened on 1st December 1997. At the time of the incident of Mr Everest's life-threatening self-harm on 22nd February 2014, HMP Altcourse was run by G4S, as it is at the time of writing this report.

Mr Everest was located on Foinavon Blue unit. Foinavon Blue has the capacity for 60 prisoners and all prisoners are in single cell accommodation. Foinavon Blue was full at the time of the incident on 22nd February 2014 and it contained prisoners of all age groups, except those aged 50-plus who were located on the adjacent unit, Foinavon Green. Prisoners on Foinavon Blue were mainly participating in vocational training (which comprised a mixture of education and practical work training). At that time, Foinavon Blue was not a 'specialist' unit. However, in the 12 months prior to writing this report in February 2017, the unit has become a specialist unit.

The report of Her Majesty's Chief Inspector of Prisons' (HMCIP) unannounced inspection on HMP Altcourse (9 - 20 June 2014) states that although the "strengths of good relationships between staff and prisoners" remain, "the prison is much less safe than at [its] last inspection." [Excerpt from paragraph 1, page 5.]

"These relationships offered good care for prisoners at risk of suicide or self-harm, although more focus was required on the lessons arising from the three self-inflicted deaths that had occurred since our last inspection. Health care was good and improving further and complaints were generally handled well." [Excerpt from para. 4, page 5]

The prison was overcrowded, with prisoners complaining about shortage of equipment, but these issues *"were offset by a spacious external environment"* to which the prisoners had access at times of general unlock. [See para. 4, page 5.]

Prisoners said that although they felt safe, under the surface of calm, incidents of assaults and bullying were *"high and rising sharply".* The misuse of 'legal highs' and *"gang issues" "were a significant factor in much of the violence"* within the prison and had led to a rise in hospital admissions. [See para. 2, page 5.]

The Independent Monitoring Board (IMB) at HMP Altcourse's report for 2013 - 2014 stated:

"The potentially challenging issue of 'legal highs' is the cause of great concern to both the establishment and the Board. The establishment have acted strongly in terms of ensuring that prisoners and staff are fully informed of the risks."

"Complaints to the Board regarding medical prescribing policy remain high and it is pleasing to note that Healthcare have been given a place on the prisoner Induction Programme. As a result, it is hoped that prisoners will have a better understanding of the policy and the national requirements and guidelines. However, it has been highlighted to the Board that there are inconsistencies in prescribing practice between prisons i.e. a prisoner refused medication in one prison, may encounter a more 'relaxed' approach to prescribing in a neighbouring prison. The Board would appreciate a national overview on this issue." [Excerpts from 4.1, page 5]

"The overall judgement the Board has of HMP Altcourse is that it is generally a good establishment, with managers and staff working at full capacity on an ongoing basis. That does not mean, of course, that there is not room for

improvement – there is; or conversely, that there are not areas of excellence – there are many such areas.” [Excerpt from 4.5, page 6]

Chapter 3 Care of Mr Everest in HMP Altcourse

Background history

The background was gathered from prison, probation and health records and from the interview with Mr Everest's mother, Mrs Fuji. The source of the information is shown in brackets.

Birth, Early Development and Family History

Mr Everest was born and bred in town 2, [in county 2]. There were no problems with his birth and early development. (Mrs Fuji, interview). His parents divorced when he was eight. Mr Everest said his father was violently abusive towards him, his mother and brother on a regular basis and that he witnessed his father commit many assaults on his mother, including stabbing and scalding her. Mr Everest's parents used to argue when he was a child and he remembered praying that they would not. His father lived locally after the separation and Mr Everest said he "brought shame on the family". He said, "It killed me when he went on drugs". He described his father unfavourably compared with the fathers of other children at school. (Prison medical records). He described feeling angry and upset about the divorce due to his father's heroin and crack cocaine addiction-related problems. (Prison medical records 2008; Mrs Fuji interview) At interview, Mrs Fuji indicated that Mr Everest's father was not violent toward the children, just her, and that prior to misusing heroin, he was not violent at all. She had met him when she was 17 and became pregnant with Mr Matterhorn [Mr Everest's older brother] soon after. After the divorce Mr Everest saw his father regularly until he became aware that he was still taking drugs and he then reduced the frequency of their meetings. He lives in town 1. (Mrs Fuji interview)

Mr Everest described a good relationship with his mother, but that she was unable to control him when he was younger. He said she lacked parenting skills, particularly in discipline. Mrs Fuji has a history of depression. (Prison medical records; Mrs Fuji interview) Mr Everest said that he had an older brother, Mr Matterhorn, born on 6th January 1981, who was severely disabled in a road traffic accident when he was 21; he

had brain damage and required 24-hour care. (Prison medical records) Mr Matterhorn got into trouble when he was 16 and was sent to a detention centre for four months but had no further arrests.

Mr Matterhorn died whilst Mr Everest was in custody. He had gone into hospital with abdominal pain and quickly deteriorated developing sepsis and organ failure. Mr Everest was described as being very close to his brother. (Mrs Fuji interview) Mrs Fuji has a close family with three brothers and two sisters. Her mother is still alive. Her sister and brother help take care of Mr Everest.

Schooling

From the age of five to eleven Mr Everest attended Mars Primary School in a district in town 2, and then Venus Secondary School, in town 2. (Mrs Fuji interview) He was expelled from comprehensive school at the age of thirteen and placed in a special school due to his behavioural problems. He only attended this school for a matter of weeks and refused to return. He had several friends at school. (Mrs Fuji interview) He attained no qualifications either at school or after leaving school. He previously stated that he needed help with literacy and numeracy. (Prison medical records 2008)

Employment

Mr Everest has never worked and was in receipt of Disability Living Allowance (DLA). In custody he was completing a kit car course. (OASys) (Mrs Fuji interview)

Relationships

Mr Everest was in a relationship with his partner for 13 years. They met as teenagers and she became pregnant at 17. (Mrs Fuji interview) He has three children, who were aged nine, six and four when he was received into HMP Altcourse on 6 December 2013. On reception into HMP Altcourse in December 2013, Mr Everest stated that he would return to live with them on release. (OASys)

In 2008, Mr Everest described that he and his partner had a good relationship, although at times he was bad-tempered and aggressive in front of the children. He stated that he wanted to be a better father and parent. He recognised parallels with his own childhood. (Prison medical

records 2008). Mr Everest's relationship with his partner was stormy; they had numerous arguments and had separated several times. (Mrs Fuji, interview). He was keen to give his children a good life and his acquisitive offending was in part to fund his partner's and children's lifestyle. He talked about missing the children greatly. (Prison medical records). Prior to going into custody, Mr Everest was spending a lot of time at his mother's because of the arguments and his use of cocaine in the week. He and his partner both used cocaine at the weekend. Since Mr Everest has returned home, his partner has indicated that she wants nothing to do with him and they are now separated. He sees the children regularly and they stay often at Mrs Fuji's house. (Mrs Fuji interview)

Recent Family Involvement

Prior to custody, Mr Everest was spending time between his home address and his mother's address. His father lives in town 1 and has been in more contact since his brother's death. (OASys) Mrs Fuji is well-supported by her family, some of whom are paid carers for Mr Everest. (Mrs Fuji interview)

Alcohol and Drugs

Mr Everest first used cannabis at the age of 15. He said it helped him relax. He last used this drug around 2011. He smoked it on a daily basis, several 'spliffs' a day [a spliff is a cigarette containing cannabis] and it tended to make him paranoid. He first used cocaine aged 18. He used it four or five times a week. He last used it the night before custody (December 2013). He was said to be addicted to painkillers, taking 10 - 15 a day. He did not feel ready to complete interventions to address substance misuse following the death of his brother. It was felt that his misuse was linked to offending behaviour. (OASys 2014)

It was noted that alcohol misuse was not linked to Mr Everest's offending behaviour, but that drug misuse was. Previously, he was found on a school roof under the influence of drugs. Also, he has had a heart attack directly related to use of substances. He has seen Counselling, Assessment, Referral, Advice and Throughcare services (CARATs) workers in custody, but not in the community. (Pre-sentence

report 09.01.2014) [CARATs are an external agency advising and helping people with alcohol and drugs problems.]

At interview, Mrs Fuji reported that Mr Everest's misuse of cocaine had been significant for the six months prior to his remand in December 2013. She also reported that after taking cocaine, Mr Everest became very suspicious and paranoid and, on coming down from the drug, would be low and tearful. She said he would be wary as though "he was looking for something ... He used to go upstairs and he'd look under the bed .... the way he was, it ... at that time, it just wasn't Mr Everest." (Mrs Fuji interview)

Physical Health

It is alleged that Mr Everest had a heart attack related to substance misuse (Pre-sentence report 09/01/2014). Otherwise, no physical health problems were noted.

Criminal History

Mr Everest had had ten court appearances when under the age of 18 and 12 when over 18 (OASys). His age at first contact with Police was 14. (OASys). This offence was Taken Without Owner's Consent (TWOC). He had previous convictions for burglaries – non-dwelling and dwelling.

Mr Everest had experienced various disposals [outcome of a court hearing], including custody and in the community. He had five previous prison sentences; the longest was two years for burglary. (Prison medical records) There was an indication that his offending behaviour was escalating. (Pre-sentence report 09/01/2014) From his OASys record, it was noted that Mr Everest was impulsive and did not think through the consequences of his actions.

Review of the Police National Computer (PNC) record revealed:-

22 theft offences

1 public order offence

10 offences related to Police/courts

8 miscellaneous offences

2 non-recordable

Mr Everest's index offence was committed on 13/11/13. The offence was burglary with intent to steal. He was sentenced at Crown Court, town 3, in geographical area 1, on 10.01.2014. (OASys). The circumstances were that whilst walking his dog, Mr Everest broke into a house and removed a portable safe. He said he was not thinking straight and he was not getting the help he needed with his mental health. He had a psychiatrist, but had missed a few appointments. He described having a hard time and that he was not in the right frame of mind. He committed the offence for money linked to drug misuse. He said he had not gone to geographical area 1 with the specific intention of committing a crime, but said he regretted it, but then justified his actions, saying he was not getting help. (Pre-sentence report 09/01/2014).

Mr Everest arrived at HMP Altcourse on 06/12/2013. There were no issues regarding his attitude or behaviour. He was on Standard level on the Incentives and Earned Privileges scheme (IEP), with no adjudications and no negative entries in his file. [The IEP scheme must operate on at least three tiers: Basic, Standard and Enhanced. Prisoners move between levels according to their behaviour. Prisoners on Standard level will be provided with a greater volume of allowances and facilities than at Basic level. Typically, these will include more frequent visits, more time for association and the provision of in-cell television. Association is prisoners' recreation and association period.]

With respect to risk of harm posed by Mr Everest in the community, risk to children was low, risk to the public was medium, risk to known adults was low. With respect to risk of harm to others in custody, all risks were low. (OASys)

Mental Health

Mr Everest had a ten-year history of depression, since the age of 13, following his parents' divorce and a history of violent abuse at the hands of his father. (Prison medical records 2008) He had self-harmed twice in the past, in 2008, but denied any current thoughts. (Prison health records 2010) He had cut his wrists 7 - 8 months previously (in the community, circa May/June 2013). The trigger to this was his way of life, taking drugs and his relationship; Mr Everest did not expand on this. (OASys 2014)

In the Pre-sentence report, it was noted that Mr Everest experienced mental health problems for some time, he was diagnosed with depression, had seen a psychiatrist regularly, he had made an attempt at suicide and self-harm in the past and he was prescribed antidepressants. It was noted that he could have difficulty coping in custody and that there were particular social and emotional consequences of imprisonment. Because he was low in mood, his mother indicated that a psychiatric and GP report had been made available, but the Probation Officer did not have access to this. (Pre-sentence report 2014)

Consideration was given to a suspended sentence, but there were concerns that Mr Everest had not sought help with his drug problems and there was escalation in offending. It was noted that there should be a liaison with psychiatric services, specific interventions for thinking and problem-solving, specific interventions on his awareness of the effects of his lifestyle on others and monitoring of abstinence from illegal substances. (Pre-sentence report 2014)

Mrs Fuji said that Mr Everest became depressed first after his granddad died, when he [Mr Everest] was in Shrewsbury Prison, and he was started on antidepressants then. He had been on them ever since. His mood was up and down. He cut himself in Shrewsbury Prison but at no other time. He was always a bit of a worrier. (Mrs Fuji, interview)

Mental health history from records

Prison mental health records 2008

14/08/2008	Transferred today to HMP Liverpool from Shrewsbury Prison. Suffers from depression. He is on medication for this. No ideas of self-harm.
05/09/2008	Mr Everest has a long history of depression, going back many years, relating to childhood and a history of violent abuse at the hands of his father. He is prescribed citalopram [an antidepressant medication]. He described feeling very tense and disturbed by thoughts relating to his history. He was located in Shrewsbury Prison where he received psychotherapy.

08/09/2008	He is serving a sentence for burglary. His offence related to organised commercial burglary with a group of friends. He was the only one caught. He has a ten-year history of depression, since the age of 13, following his parents' divorce, with a history of violent abuse by his father prior to this age. He is feeling angry about the divorce and his father's heroin addiction-related problems. He has been prescribed citalopram by his GP for the last twelve months. He complies with medication, but does not think it helps him. He has made efforts to get help for his problem, began counselling at community health and/or substance misuse facility 1 in city 1 [counselling services from a third sector provider]. He had been referred there by his Probation Officer. In Shrewsbury Prison he was working with a psychotherapist. He says he is always depressed and sees himself as a failure. He has never been happy. He feels angry inside. He recognises that this is a problem and he wants to live a normal life. He has noticed some improvement since engaging in Talking Therapies [a range of psychological interventions involving assessment and advice/counselling]. His sleep is poor. He is normally awake around 4.30 a.m. He has poor appetite and has lost weight since coming into prison. His grandfather died during this sentence and he is unable to attend the funeral. His wife is also pregnant with their third child. There is no history of deliberate self-harm. He has had suicidal thoughts at times. He began taking cannabis at the age of 15. He used cocaine from 18. He described occasional weekend use. Mr Everest was born and bred in town 2. His parents divorced when he was 13. Mr Everest said his father was violently abusive towards him and his mother on a regular basis and he witnessed his father commit many assaults on his mother, including stabbing and scalding his mother. They [his parents] used to argue when he was a child and he remembered praying that they would not. His father lived locally after the separation and he [Mr Everest] said, "he brings shame on the family". He said, "It killed me when he went on drugs". He described his father unfavourably compared with the fathers of other children at school. He said he began to develop a lot of anger and that this anger remains. He described a good relationship with

his mother, but that she was unable to control him. He said she lacked parenting skills, particularly in discipline. He said that he has a younger brother who was severely disabled in a road traffic accident seven years ago; he is brain-damaged and needs 24-hour care.

Mr Everest was expelled from comprehensive school at the age of 13 and placed in a special school due to behavioural problems. He only attended the school for a matter of weeks and refused to return. He had no qualifications. He has never worked.

At this time he has been with his partner for seven years. They have a good relationship, although at times he is bad-tempered and aggressive in front of the children. He has two children, aged four and one, and his wife is currently pregnant. He wants to be a better father and parent. He recognised parallels with his own childhood.

The plan was to have his medication reviewed by the GP and refer to Primary Care Psychological Services.

17/09/2008 Irritable and angry. Attended initial session and engaged well with psychological therapist.

24/09/2008 Continued assessment for psychological therapy. Engaged and negotiated a course of CBT (Cognitive Behavioural Therapy) [This is a talking treatment], up to twelve sessions, to build understanding of his difficulties. Aim is to learn strategies to manage his negative thoughts.

06/10/2008 Seen by a psychotherapist. Reviewed needs.

04/11/2008 Letter to Mr Everest from Miss Hyacinth, Mr Everest was referred to Primary Care Psychological Services in September 2008 with difficulties with low mood and anger. We met for three assessment sessions and two therapy sessions. Mr Everest attended all sessions and described difficulties including intrusive thoughts and nightmares of violence witnessed as a child, high levels of stress, low mood, anger and anxious thoughts. The aim was to learn to manage the negative thoughts to feel less stressed. Following assessment, we negotiated for him to commence a course of CBT, up to twelve

sessions. If he is released from prison to complete this in the community.

12/11/2008 Did not attend psychotherapy session. No reason given.

19/11/2008 CBT. Finding it difficult to verbalise his negative childhood experiences. Becomes frustrated that he cannot just forget. Explored why intrusive thoughts remain intrusive. Continues to slowly disclose experiences.

26/11/2008 CBT. Preoccupied with his HDC (Home Detention Curfew) board which sits 27/11/2008. His desire is to go home because his baby is due. Feeling stressed and has difficulty coping due to rumination.

03/12/2008 CBT. Advised that he has been successful in gaining his tag and is due for release on 15th. Discussed referral letter to his GP requesting further psychological therapy.

Miss Hyacinth wrote to the GP describing that he had had some therapy and suggesting that he was referred for further assistance.

Analysis of mental health input in 2008. Professor Jenny Shaw

- Good background history documented
- A medication review was recommended by the GP in custody but it is not clear whether this happened and what the outcome of this was.
- He had some psychological therapy, which he found helpful.
- He was referred back to the GP in the community and his psychotherapist suggested further therapy on his release.

Prison mental health input in 2010

15/04/2010 HMP Preston. On reception he was noted to have previously self-harmed in 2009. He cut his wrists and had a history of depression and anxiety.

23/04/2010 He was seen on the wing. He states he has been taking citalopram in the community and received counselling. Wishes to recommence [the drug].

15/09/2010	HMP Hewell, in Redditch, Worcestershire. Walked out of mental health assessment appointment. On citalopram.
16/09/2010	He was saying he felt low in mood and was concerned that he had moved so far away from his girlfriend and three children. Appeared angry. On citalopram. Cut his wrists two years ago in prison. Worried about his mother who is looking after disabled brother.
03/10/2010	Change to mirtazapine.
11/10/2010	HMP Kennet, in Liverpool. Became aggressive towards healthcare staff this morning.
12/10/2010	Seen by RMN. Primary Care Mental Health assessment completed. Mr Everest is a twenty-five-year-old man serving a two-year sentence for commercial burglary. He was prescribed anti-depressants in HMP Shrewsbury in 2007 after the death of his grandfather whom he described as a father figure. He was unable to attend the funeral for security reasons at that time. He is on citalopram which was increased to 40 mg then 60 mg. Initially, 60 mg had the desired effect, but no longer. He is struggling with thoughts and arguing with thoughts, which he denied were to hurt himself or others. He said that they were derogatory in nature, but he was not specific. He said that they were not voices. He described being anxious and physically tense, sweating at night and that he had difficulty communicating these thoughts and feelings to others. There was a history of domestic violence during his childhood from his father. He said his mother and brother were also victims. His father was a heroin and crack cocaine misuser. His [Mr Everest's] education was limited. He has no qualifications and believes he needs help with literacy and numeracy. He has never worked and uses cannabis and alcohol / cocaine as coping mechanisms. He had self-harmed twice in the past, in 2008, but denied any current thoughts. Overall impression was he suffered from depression and might need a change in medication.
18/10/2010	Seen by a Mental Health Nurse at HMP Kennet. Presented as sullen in mood and stressed. Described being in therapy in city 1 in 2007, but did not complete as he was transferred out. Described current sleep problems. He was ruminating on past abuse as a child. He

described his previous self-harm, complaining that persistent depression was the trigger. Support from his mother and partner and has three young children. He had pessimistic thinking about the future. No plans for the future. He has thoughts of hopelessness and worthlessness and anhedonia. [Anhedonia is defined as an inability to feel pleasure in normally pleasurable activities.] He said he had horrible thoughts throughout the day, more prevalent at night. No triggers identified for this. Other coping strategies apart from using "skunk" were discussed. [Skunk is a potent form of cannabis.] He was advised to work through stress and anxiety workbooks and given information about mirtazapine.

26/10/2010	On segregation unit. He received a head injury whilst being relocated to segregation unit. In segregation unit he was pacing the cell.
26/10/2010	Seen by Mental Health Nurse, who discussed his recent behaviour. He claimed to have a razor blade on his person and that he would self-harm should he not be reviewed by healthcare. Admitted to "playing the game" whilst on segregation. He reported struggling with his current titrating medication regime. [Titration is the gradual change in dose of medication, proportional to response and/or side-effects.] He believes that this has exacerbated his impulsivity and irritability. He had poor sleep hygiene and on-going stress. Talked about his behaviour and the need to improve this in order to be relocated from the segregation unit.
29/10/2010	Remains low in mood. Reports feeling stressed of late. Spent three days on the segregation and is now back on the induction wing. He asked if he can move into full-time work as he spends a long time locked up where he ruminates on the past. He presented as a little agitated. Denied thoughts of harming others. Discussed stress reduction techniques. Continue titrating medication regime.
08/11/2010	Said he was frustrated because of the titration of medication making him feel more irritable, depressed, angry and withdrawn. He had been given an extra twenty-five days sentence because of his behaviour leading to segregation. He ventilated his thoughts. He became angry, but calmed down. He said he cannot be blamed for his actions if it is to do with medication.

10/11/2010	Mental Health Nurse. Discussed being stressed and angry in relation to the titration. Discussed the need for him to take responsibility for his actions in spite of the effects of medication. Discussed that many of the features he was experiencing were related to his personality. Denied suicidal ideation plans or intent.
13/11/2010	Staff continue to be concerned by his presentation. He has cancelled his visit on Sunday. When telephoning Mr Everest's mother, she informed Mr Wear that she is very concerned by his behaviour, finding him depressed and very low. Advised that an ACCT be opened.
13/11/2010	Attended ACCT review. Two officers and Mr Everest also in attendance with RMN. Discussed current presentation, recent behaviour, but he had no thoughts of self-harm and was annoyed that an ACCT had been opened. Talked about his mother phoning the Chaplaincy and voicing her concerns and worries. Discussed low mood and depression presentation and that his coping strategies have diminished of late. Mr Wye, SO, appeared reluctant to leave the ACCT document open as Mr Everest denied any current suicidal ideation. However, there were concerns that he still depressed. Agreed to keep ACCT open.
17/11/2010	ACCT review. Mr Wye, SO, read the entries in the ACCT document. Since it was opened, Mr Everest had not agreed with the plan. He fluctuated, blamed the change on his anti-depressants. Interacted more with his peers. He began a course yesterday, had a visit from his girlfriend and his mother and resolved the issues that arose from a previous visit. He expressed no thoughts of self-harm and suicide. He acknowledged the reason for the ACCT being opened. It was decided that the ACCT should be closed.
18/11/2010	History of depressive features since childhood physical abuse. No current depression. Diagnosis: Mixed Personality Disorder, dissocial traits, emotionally unstable traits, impulsive, no convincing depression. Plan: Continue medication. [Dr Buttercup, Psychiatrist]
11/12/2010	Discussed current presentation. Presented more cheerful. Improvement in depression. Pessimistic thinking.

12/01/2011	Very upset and low in mood. His brother is in ITU [Intensive Therapy Unit] with pneumonia
22/01/2011	He has gained two stone in weight. Advised to continue medication.
13/04/2011	He is due to move to HMP Ford [in Arundel, West Sussex] on 18/04/2011. He discussed the pros and cons of the move as it is located a long way away, but it is Cat D. Due for release September 11th. Felt positive about the future.
10/06/2011	HMP Kirkham [in Preston, Lancashire] Receiving anti-depressants for mental health problem.
05/09/2011	Seen for brief intervention. Had a couple of cans of lager on his town leave at the weekend. Said no problems with alcohol in the past. Was very remorseful.
06/09/2011	Transferred to [HMP] Kennet as he had been drinking alcohol on a home visit. Due to be released on 21st. Maintained on mirtazapine.

Analysis of care: 2010 – 2011. Professor Jenny Shaw

- History-taking was reasonable.
- ACCT reviews were multidisciplinary with discussion of risk.
- He was encouraged to take responsibility for his own health.
- He was seen by psychiatrist, diagnosis noted.
- Diagnosis of personality disorder
- He had multiple prison moves.
- There was no comprehensive treatment of his substance misuse.

Community GP Records up until December 2013

13/11/2007	Depressed mood since coming out of prison. Lacks motivation, no appetite for twelve months. Negative self-image. Poor sleep pattern. Stays awake until 3.00 a.m. No thoughts of deliberate self-harm. Stopped socialising. Attending counselling. Endogenous depression [a type of depression without an external cause]. Prescribed citalopram.

14/12/2007	Has started to feel better with citalopram.
05/03/2008	Had a chat about mood, the same, does not get out of the house. Going to weekly counselling. Continue citalopram.
03/04/2008	Depressed. On medication but slow response. Some changes. Attending counselling.
23/12/2008	Counsellor referral form completed.
20/01/2009	On citalopram.
17/03/2009	Reviewed. Never got anything from counselling. Keen to restart CBT which had been started in prison. Will ask to rearrange. Does not feel meds are working. Chatted about the options. Does sometimes feel suicidal, with thoughts of hanging himself, but no plans to carry out. Protective effect of children.
03/04/2009	Letter from Primary Care Mental Health to say that they had not been able to get in contact with Mr Everest.
13/05/2009	Depression. Very low. Deliberate self-harm whilst detained. No true protective influence of family. Not sleeping. Low mood.
18/01/2009	Cannabis-type drug dependence. Using cannabis at night to help sleep. Makes him feel worse in the morning. Advice given. On citalopram.
29/09/2009	Did not attend mental health review, therefore discharged.
30/11/2009	Poor sleep pattern.
10/06/2010	Medication given. Just released from HMP. Changed onto citalopram whilst inside. Doing much better. No thoughts of deliberate self-harm. Continue on the citalopram.
23/09/2010	Medication changed to mirtazapine
21/10/2011	Reviewed. Depression the same. No thoughts of deliberate self-harm. Awaiting counselling. Admits stress levels are high during the day. Feels on edge all of the time. Prescribed a small dose of propranolol.
17/11/2011	Mood still very low. Does not see the point of being here. Negative thoughts. Has had a bad life. Feels as though he has no future, no job or qualifications. To see counsellor this week.

13/01/2012	Mood still very low. Gets stressed out by daily life in general. Can't cope. Thinks about cutting wrists. Has not actually done so in a long time. Has a young child. Stressful. When he cannot cope he goes to stay with his mother. Tearful. Does not feel mirtazapine has worked for him. Can't sleep. Given time to chat and discuss options. To wean off mirtazapine and try sertraline. Advised to call counselling team.
30/01/2012	Bit of a struggle coming off mirtazapine. Noticed his mood picking up since starting sertraline two weeks ago. Still a long way to go. No thoughts of deliberate self-harm.
13/02/2012	Said mood a bit more settled. Drowsy in the mornings. Sleeping until 11.00 a.m. Spoke to Crisis team who invited him down to Hospital 1, but he did not go. He said he did not like the guy he spoke to. No thoughts of deliberate self-harm. Suggested he try taking amitriptyline earlier in the evening.
15/03/2012	Feeling a little better. Things are not as bad as previously.
26/03/2012	Still lacking in motivation. No suicidal ideas.
20/04/2012	Feeling a lot better. Tried phoning for counselling. History of road traffic accident. Not wearing seat belt.
22/06/2012	Stable on sertraline. Decrease in thoughts of self-harm. Awaiting counselling.
20/07/2012	Continues to do well. Says the tablets are kicking in. Seems to be thinking more clearly. Not finding as many things to worry about.
22/10/2012	Still waiting for counselling. Mood low. Having lots of bad days. Trying to wean himself off sertraline. Had a chat.
16/11/2012	Depression. Repeat script [prescription].
12/12/2012	Had a chat. Feeling good last few days.
04/01/2013	Continues to make good progress.
08/02/2013	Depression. Medication review. Agitated. Not sleeping. On sertraline. Keen to revert back to mirtazapine. Had a chat. Change to mirtazapine.
04/03/2014	Still on mirtazapine. Improving.

13/03/2013	Depressed mood. Admitted to suicidal thoughts. History of cocaine misuse last three weeks. Associating with old friends. Feels worse and agitated. Appointment with CMHT due to cocaine. Would like to go to Addaction [a third sector provider of substance misuse services].
22/04/2013	Patient's condition worse and feeling very low. Assessed on self-presented at community health and/or substance misuse facility 2 [an NHS Community Mental Health Team facility in city 1]. Said he needed to see a psychiatrist. Admits to hearing voices, paranoia, sees shadows, feels as though he needs to go somewhere to get support. Uses cocaine, but only occasionally. Suicidal intent. Now just wants some help. Will discuss at MDT [Multi-Disciplinary Team]. On mirtazapine.
05/06/2013	Brought into Hospital 1. Found running on the roof. Admitted to taking cocaine earlier. Has on-going depression. States this has caused him to take cocaine. Due to see Mental Health team next week. On mirtazapine.
27/06/2013	On mirtazapine and quetiapine.
23/07/2013	Medication review. Increase mirtazapine. Introduce quetiapine. Under CMHT and Early Intervention team. [These are both mental health teams. Early intervention services provide treatment for people with suspected or actual psychosis.]
12/08/2013	Seen in Psychiatry Clinic.
12/08/2013	Requested mirtazapine.
20/08/2013	mirtazapine.
09/09/2013	Going to the gym on Dr Dandelion's psychiatrist advice. Felt good, then stopped because he was "going at it" 110%. He had too much pain. He stopped taking quetiapine, as it made him feel weird.
01/10/2013	Had hypnosis today. Mother paid for it. "I feel alright". Not stressed.
16/10/2013	Says not using illicit drugs at the moment.
12/11/2013	Has been asked to go for work plan review. Does not feel fit to attend.
03/12/2013	Managed to wean himself off co-codamol.

Letters in GP records prior to February 2014

22/12/2008 Letter to the GP from Miss Hyacinth, cognitive behavioural psychotherapist. He was referred in HMP Liverpool in September 2008 with difficulties with low mood and anger. He had intrusive thoughts and nightmares of violence witnessed as a child, high levels of stress, low mood, feelings of anger towards his father and anxiety. Following assessment, he started on CBT for up to twelve sessions. He attended for five sessions but then was released on tag. He engaged well and began exploring cycles of stress. He was in the early stages of therapy when released and would benefit from continuing it in the community.

27/3/2009 Miss Violet, psychological therapist. Wrote that Mr Everest presents with a history of having been involved in crime since sixteen. Described low mood and worry over having to be strong for his family and not being able to manage stressors. He disclosed having engaged with self-injury whilst in prison, with head-banging and lacerations. He used cannabis to deal with his feelings. He wanted to receive counselling. He was discharged from Primary Care Mental Health on 18 February 2009 because he had failed to make contact with the service.

1/5/2012 Failed to attend for CBT.

25/1/2013 He was screened by the Mental Health Team for therapy but disclosed some suicidal ideas so was referred to the Acute Team at town 2 [county 2].

5/3/2013 He was discharged from the Mental Health Team as he had not attended.

4/6/2013 Dr Dandelion, consultant psychiatrist: He was seen in clinic. Gave a history of cocaine use, three times a week costing £30. He described ending up on the roof, apparently going to jump off last week, denied wanting to kill himself. He sometimes drinks alcohol with cocaine but only one or two cans. He started hearing voices under the influence of drugs. Feels paranoid about other people. He has been referred to Primary Care psychology and is awaiting appointment. Referred to

	Addaction. Dr Dandelion added a small dose of quetiapine to give him better impulse control.
5/8/2013	Miss Bluebell, Early Intervention Practitioner: He was assessed using the PANNS [positive and negative symptoms scale for schizophrenia assessment], he was well-kempt, he had been on antidepressants for four years, his main difficulty was depression but recently a drug problem using cocaine. Whilst under cocaine he climbed on to a roof and when examined in A&E was found to have suffered a mild heart attack. He said that he has been in and out of prison. He made reference to having demons and devils in his head but there was no suggestion that he was experiencing voices. He did appear distracted and preoccupied and he reported that he had been prescribed quetiapine which made him "spaced out". He said that he had recently slashed his forearm with a knife. He reported having suicidal thoughts but no plans or intention. On the PANNS there is no evidence of low mood, no psychotic symptoms, no delusional ideas. He last used cocaine on 14 July 2013. The triggers for using it were when he was out in the pub or feeling strained. Mr Everest reporting of unusual experiences such as feelings of paranoia and hearing sounds only occur when he has taken cocaine.
25/10/13	Dr Dandelion. He saw Mr Everest with his mother in the outpatient clinic on 25 October 2013. feels unchanged, taking cocaine on a regular basis, smokes cannabis every night. When he tries not to take cocaine for three or four days his mood drops, he starts shaking and is desperate to have cocaine again. He said he took prescribed quetiapine for four days but did not like how it made him feel. His mother is emotionally involved, she is distressed about his drug problem, the high expressed emotion leads to significant tension between them. He recognises he is not good at coping with stress. Mr Everest was keen to engage with Addaction. Increase dose of mirtazapine to 45 mg, awaiting appointment for Addaction. Quetiapine was stopped. No evidence of psychosis. Reported hearing voices when under the influence of drugs. Diagnosis: Harmful use of cocaine, moderate depressive episode, occasional psychotic symptoms. Increase mirtazapine to 45 mg per day from 30.

Summary of community records. Professor Jenny Shaw

- Mr Everest was seen by secondary mental health services including the Early Intervention team.
- He was seen by substance misuse services.
- There was evidence of good history-taking.
- There was a clear description of misuse of cannabis and cocaine.
- The diagnosis by the psychiatrist was: Harmful use of cocaine, moderate depressive episode, occasional psychotic symptoms.
- He was prescribed mirtazapine 45 mg in last encounter prior to custody in December 2013.

Reception into HMP Altcourse, Liverpool, December 2013, to life-threatening self-harm February 2014

Chronology of events: medical records, prison records, probation records

05/12/2013	Person escort record form: No markers on PNC [Police National Computer]. Tested positive for drugs. Depression
06/12/2013	Cell sharing risk assessment: No thoughts of suicide or self-harm. No issues sharing a cell.
06/12/2013	Reception screen: Does not feel like self-harm or suicide. Has not tried to harm himself in prison or in the community. Reason to see Dr [Doctor] - medication review. Noted had been on mirtazapine 30 mg for four years. Saw Dr [Doctor] 2 weeks ago for cocaine addiction and depression. Sees regularly for depression. Noted to have seen a psychiatrist.
06/12/2013	Claims on mirtazapine. Not had for 2 days. A bit low, nil self-harm ideation.

Plan: Chase medication confirmation. ? Refer to MHT [Mental Health Team]. [Dr Bergamon]

07/12/2013 First night watch observation sheet. Nothing remarkable.

10/12/2014 Facsimile from GP Surgery to HMP Altcourse. Noted he was on mirtazapine 45 mg per day.

10/12/2013 Mental health assessment. Long history of depression diagnosed by the GP. He is finding mirtazapine effective with no side effects. Coping well at this time. No current thoughts of self-harm or suicide. Signed consent form for GP confirmation [of his medication].

[Miss Gladiolus, RMN, nurse access role]

10/12/2013 History received from GP. Forwarded to Dr. (Administration role)

12/12/2013 RMN at [HMP] Kennet started him on mirtazapine in 2012, although the assessment at the time did not see him suffering from major depression, which is what mirtazapine is licenced for. I believe he is agitated that he has not had prescription of this since arriving here and is demanding to see the GP today. Hardly the behaviour of someone who is suffering from major depression. Plan: Reducing dose of mirtazapine to zero followed by RMN review. [Dr Tulip General Practitioner.]

17/12/2013 Mr Everest has asked to see a RMN he has depression and needs counselling. Seen by Mental Health on the outside. Depression. Noticeably low in mood. Anxious. [Miss Forth, PCO]

17/12/2013 Health care application form. Mr Everest wrote that he wanted to see someone about mental health problems. Stated he was under mental health outside. He received treatment for his problems but had not seen anybody in prison.

19/12/2013 Follow up psychiatric assessment. Mr Everest had entered a request to see the RMN team as he said he was not receiving the support he receives in the community. His main concern was that in the community he was receiving prescribed medication. He failed to mention any other concerns. He says in the community he suffered from addiction to prescribed drugs and cocaine and sees a psychiatrist, Dr Dandelion, at community health and/or substance misuse facility 2 every fortnight for depression. He denied any

current withdrawal, saying that he had done his rattle and feels physically well. Advised on the objectives of the CARATs team and said he would like to be referred to them. Referral made. He engaged, had a good rapport. No evidence of hostility. He denied any psychosis he said his mood is currently low and relates this to the fact of having to wait for prescribed medication and the fact he has nothing to do in the day. He says he is a negative thinker and prefers distractions to avoid deterioration in mood. He said he has been informed by officers that he would be starting work in mechanics today. He was advised that things would not happen straight away necessarily. He denied any current thoughts of deliberate self-harm. He cited his partner and three small children as protective. He states he is carrying on his daily living activities and knows how to contact Primary Care Mental Health.

Plan: Refer to CARATs, counsellor and RMN review.

[Miss Lupin, RMN]

19/12/2013	States addicted to cocaine. Having treatment in the community. Desire to remain drug free. Mr Beech, substance misuse worker
23/12/2013	Triage. Wants to see Doctor for review of medication-added to list. Miss Clematis, RMN nurse
31/12/2013.	Triage. Wants to know where he is on GP waiting list-Currently 73. Has had medication reduced. Feeling unwell. Listed for Dr to discuss reasons for this. Miss Freesia, nurse.
02/01/2014.	Concerned reduced mirtazapine. Feeling down every day. No diurnal variation. [Diurnal variation: Mood worse in the morning; this would be typical of a depressive illness]. Worries about things, family, partner and three kids. Examination. Slightly agitated. Mild anxiety and depression. Continue reducing mirtazapine and introduce sertraline. Sertraline 50mg prescribed. Dr Tulip. GP.
03/01/2014	Collected medication.
03/01/2014	Mental Health referral form from CARATs. There are mental health issues. Has a psychiatric history. He has self-harmed due to poor coping skills in the community by cutting right arm. No current thoughts of self-harm. Mr Beech

05/01/2014	Client refused to take medication due to side-effects. Mr Clover nurse
6/01/2014	Mr Everest in a distressed state. Not receiving the medication for mental health issues he had been on in the community (mirtazapine). Said the ones the doctor wanted to give him he had previously tried and they gave him side effects, so he refused to take them. He was waiting to see mental health. Unable to complete any paperwork. Mr Beech, Substance misuse worker
09/01/2014	Pre-sentence report. (See content in background) Had several previous convictions of a similar type. He has received various disposals, including custody and community penalties. He partly resides with his girlfriend and partly at his mother's address. He has three children with his ex-partner. Noted he had seen CARATs worker in custody, but not in the community. It is noted that he experienced mental health problems for some time, diagnosed with depression, seen a psychiatrist regularly, made an attempt at suicide and self-harm in the past, prescribed antidepressants. Tearful during interview. Mentioned concerns to HMP Altcourse staff. Demonstrated impulsive thinking. Uses inappropriate problem-solving strategies. It was noticed that he could have difficulty coping in custody and that there were particular social and emotional consequences of imprisonment [for him]. Because he was low in mood his mother indicated that a psychiatric and GP report had been made available, but the Probation Officer did not have access to this. Concluded there was risk of serious harm and medium likelihood of re-conviction. It was noted that he had a variety of personal problems, poor self-image and dissatisfaction with current lifestyle. Asked for help with his drug use. Consideration was given to a suspended sentence, but there were concerns that he had not sought help with his drug problems and there was escalation in offending. Custodial sentence would have the advantage of protecting the public. It was noted that there should be a liaison with psychiatric services, specific interventions for thinking and problem-solving, specific interventions on his awareness

of the effects of his lifestyle on others and monitoring of abstinence from illegal substances. Miss Oak, Probation Officer

09/01/2014 Not happy as mirtazapine stopped. Feels terrible without mirtazapine. 'a lot going on in my head' 'psychotic thoughts' seeing Dr Dandelion. Almost pleading with me to put him onto mirtazapine. Only took 2 doses of sertraline. Agitated +. Plan: task admin to contact psychiatrist and refer to RMN [Registered Mental Nurse]. Dr Tulip. GP

09/01/2014 Letter given by Healthcare Manager, with concerns from Mum about his medication. Miss Orchid, Nurse Access role.

09/01/2014 Follow-up psychiatric assessment referral from Dr Tulip and Miss Hydrangea, RMN. Spoke to Mr Everest today. Engaged well. Speech coherent. He said he was low in mood. He said this was down to not having mirtazapine for the past week. He said he has tried citalopram and sertraline in the past, but to no effect. He said he was diagnosed with depression by GP in 2005 and is under the psychiatrist, Dr Dandelion. He said mirtazapine helps get him through his life and function on a daily basis. He has started to feel despair, hopelessness and does not know what to do to remedy this. Reassurance given with little effect as he feels his request to recommence will not be considered. I said I would relay this to Dr Tulip. Denied any current ideas of suicide and self-harm. Said his family were protective. Plan: remain on RMN follow up. Miss Poppy, RMN, Nurse Access role

09/01/2014 Went back to see Mr Everest. Not seen mental health. Said had a doctor's appointment in half an hour. Told him to discuss medication with GP. Saw him when he returned. He said Dr would confirm medication and would prescribe. Agitated. No intention of self harming. Refer to mental health. Mr Beech, Substance misuse worker

09/01/2014 Mental Health referral Form

Mental health issues worse. Has a psychiatrist and mental health worker in the community prescribed mirtazapine but not given this but given substitute, with side effects and stopped these meds. Could he be seen? Mr Beech

10/01/2014	Spoke to Mr Everest Presents low in mood and is frustrated why he has been asked to sign a consent form again as he has already done this. He said he feels he has been treated unfairly, experiences hopelessness and despair. Reassurance was given. He said he had been sentenced to twenty-one months and does not know how he will get through it without mirtazapine. He states he has a history of self-harm. Denied current suicidal self-harm ideation and is aware of how to contact healthcare. Pleaded with me to try and get this sorted. Plan: Daily RMN review as very low in mood. Miss Poppy, RMN, Nurse Access role
10/01/2014	Still has not been given any meds. Still in an agitated state. Discussed with Miss Poppy, RMN, nurse who said Dr not prepared to prescribe. Tried to speak to Dr but not in until 14th. Completed mental wellbeing form with Mr Everest. Mr Beech, substance misuse worker
10/01/2014	Security records. Mr Everest convicted of a crime on 13 December 2013. Sentenced to twenty one months in imprisonment at The Crown Court, town 3.
10/01/2014	Experienced mental health issues for some time. Diagnosed with depression. Seen psychiatrist. Self-harmed in the past. Prescribed anti-depressant. Miss Pine, Probation, HMP Altcourse
11/01/2014	Seen today at follow up. Low in mood. Crying, saying he has not slept for days. He says that he has a history of self-harm and has scars on his arms. Says his mental health was improving on mirtazapine as other anti-depressants he has tried give bad side effects. Mood was flat. Denied current ideas of self-harm. Says his mind is “fast” and he is unable to control negative thoughts. Plan: daily RMN review and GP appointment for medication review. Miss Rose, RMN, Nurse Access role.
12/01/2014	Seen for daily RMN review in healthcare. He said yesterday a nurse promised to get the mirtazapine back, therefore his mood lifted and he feels better than yesterday, but he still had low mood. He said his sleep and appetite is poor. Says he was feeling well on mirtazapine and for some reason the doctor stopped it due to him refusing to take sertraline. He is now on no medication. He says he has got a formal

	diagnosis of depression diagnosed by his GP. Made good eye contact. Advised him that he will continue to see the RMN team. He had a doctor's appointment on Tuesday. Advised him to attend triage tomorrow and ask that the nurse speak with the doctor regarding medication. No family history of mental illness, however he has a history of self-harm attempts. Said last self-harmed eight months ago when he cut his wrist. He showed small scar on each wrist. Says he is currently working as a mechanic in the prison and enjoys the job. Says he had been prescribed citalopram and sertraline in the past, but experienced side effects. Denied psychotic experiences. Says he feels he is losing weight. Currently 61 kg. Plan: Remain on daily RMN review. Doctor to review medication. Miss Wisteria, nurse access role.
13/01/2014	Says feel the same. Low mood. Appeared flat in affect. [Flat in affect means lacking emotional expression.] Frustrated about not having any medication. Advised Senior Nurse Miss Orchid will discuss this further with GP on Wednesday. Has appointment tomorrow with GP. Described previously on citalopram and sertraline. Had previous side effects of hot flushes, tense jaw, grinding teeth. Described when first prescribed mirtazapine helped him to have motivation. Also sleep and appetite are poor. Says he currently works at kit car. He said it is an effort to go and he feels fed up. Described intrusive thoughts. States he is always questioning himself. Confidence and self-esteem low. Advised to try coping strategies. He says they do not work. Says he does not socialise on the unit and keeps himself to himself. Denied any current plan or intent for deliberate self-harm. He has good support networks, including his girlfriend. Advised how to contact services. Plan: Remain on daily RMN review. Refer counsellor. Miss Daisy, RMN, Nurse Access.
14/01/2014	mirtazapine works for him. says he lacks motivation and has been seen by various members of health care. Looking at GP records, has been prescribed Antidepressants for several years now as well as courses of zopiclone [a sleeping tablet] and amitriptyline [an antidepressant]. I suspect the sedative affect is the main reason for preference for mirtazapine instead of first line drugs. He was angry

	and vocal about his demand for mirtazapine. Plan: mirtazapine in the morning as RCGP [Royal College of General Practitioners] guidelines. Dr Tulip, GP. Seen later that evening by Miss Daisy, RMN, Nurse. More settled. Engaged well. Felt better after seeing the doctor today and having medication prescribed. He had a counselling session and it helped him to offload his issues. Plan: Remain on RMN daily interventions. Commence medication. Remain in contact with counsellor. Promote coping strategies.
14/01/2014	Has been told that he is going to be prescribed mirtazapine. We will see him next week to complete substance misuse mapping form. Mr Beech, substance misuse worker
15/01/2014	He said he had received his first dose and felt sedated, but was otherwise well engaged. He said that he wanted to miss work, but he was encouraged to attend. He said his anxiety had decreased since confirmation of his medication. Plan: taking him off daily RMN intervention. Currently under the care of CARATs and counselling team and stated that weekly intervention would be adequate to monitor his mood. Miss Lupin, RMN, nurse
17/01/2014	Seen in healthcare. Lethargic and tired. Sedated by medication. Annoyed that he feels so tired. He was angry Says he is “pissed off” as he was banged up behind his door due to not attending education because he feels too tired. Denied current thought, plans or intent of self-harm and no suicidal ideation. Eating and sleeping OK. Plan: RMN as required. Miss Clematis, RMN, Nurse Access role.
20/01/2014	Seen in triage. Wants medication increase. Advised on Dr's waiting list. Miss Wisteria. Nurse
21/01/2014	Telephone call from Mr Everest’s mother to say that his brother has been taken into Hospital 2 [in city 1] with pancreatitis. She was due to visit Mr Everest but this may not happen. Told Mr Everest. He asked for a phone call. Spoke with Mr Lune, PCO. Agreed to the request. Mr Everest had the call. Received another call from Mr Everest’s mother saying that the brother’s vital organs were shutting down. Was not expected to last the night. Contacted Mr Ash in Chaplaincy.

21/01/2014	Person escort record form, Travelling to Hospital 2. Risk Indicator: Fighting. Violent. Mr Tees, PCO
22/01/2014	Met with Mr Everest. He had been taken to see his brother. Mr Everest was feeling down. As Mr Beech was leaving his cell, Mr Ash arrived and said that his brother had died at 10.00 am this morning. Visit arranged with mother. Informed mental health and counsellor. Mr Beech, substance misuse worker 15.53 NOMIS transfer record Broke some bad news to Mr Everest today. His brother died. He took it badly, finding it hard to cope with emotions. Arranged for mother and partner to attend. Offered chaplaincy and counsellor. Asked staff to keep an eye on him. No thoughts of self-harm. Mr Ash, Chaplain.
22/01/2014	Met with Mr Everest and Miss Lupin, nurse. He said he was going mad, but after explaining his symptoms to Miss Lupin she said that was natural at this stage and things would get better. Wanted to get the funeral over with. Mr Beech
22/01/2014	Crisis intervention due to sudden death of Mr Everest's brother, Mr Matterhorn. Spoke with Mr Everest today in his cell. He spoke of his grief, shock and how close he was to his brother. He said he worried about the rest of the family. He said that he feels helpless because of his circumstances, but understands this is something he must accept and get support from Primary Care Mental Health and the prison counselling team involved. The Chaplain has also seen him. He said that he needs to stay strong for the sake of the family and denied any current ideas of suicide or self-harm. Plan: Placed on daily RMN intervention. Follow up psychiatric assessment. Miss Poppy, RMN, Nurse.
22/01/2014	Telephone call received from the wing with regards to Mr Everest requesting to speak to the Mental Health team about the death of his brother. Explained he would be seen the following day. Miss Clematis, RMN, Nurse Access.

23/01/2014	Slightly unkempt in appearance. Appeared tired. His mood had dipped. State of shock in relation to the death of his brother. Feels empty inside and worn out. He feels useless in prison while his mother makes the funeral arrangements. Denied current thought, plans or intention of suicide or self-harm. Said he must be strong for his mother. Plan RMN review daily. Mr Dahlia, RMN, Nurse.
24/01/2014	Low, flat affect. Slightly unkempt. Spoken to his mother and felt better. Frustrated that she could not help, although girlfriend is offering his mother some support. Not attending work. Says his concentration is poor and his memory. He is quite keen to discuss his current mirtazapine dose. Is fourth on the list. Denied suicidal ideas. Plan: daily RMN. Mr Dahlia, RMN, Nurse.
24/01/2014	7.32 pm. Telephone call from the PCO [Prison Custody Officer] on the unit to Miss Gladiolus, RMN, Nurse, saying that Mr Everest drained and lethargic and requesting advice. Remain on daily RMN review. Advised ACCT if ideas of self-harm.
24/01/2014	19.39 NOMIS transfer record Emergency buzzer. Laying on bed, saying he was hallucinating and felt his body was shutting down. Phoned healthcare, said he was under daily RMN review. Nurse then spoke to Miss Gladiolus, RMN, nurse who said it was grief and they would see tomorrow. Miss Tigris, PCO
25/01/2014	Attended. Signs and symptoms of low mood, eye contact focussed on the floor. He discussed experiencing intrusive, negative thoughts. Finding it difficult to make decisions. Reassurance given. He said he had no motivation to do anything. He said he wanted an increase in medication. Advised that he is 4th on the list for the doctor. Spoke of his brother's death and how he had to be strong for the family. Encouraged coping mechanisms other than reliance on medication. Plan: daily RMN review and encourage positive coping. Miss Daisy, RMN, Nurse.
26/01/2014	Similar presentation to yesterday. Mood up and down. Discussed negative thoughts but has times where they go. Encouraged to keep

	diary of what he is doing when they stop as this could be a time when he is distracting himself. He says he is going to the funeral and glad that he can support his mother. Mr Everest discussed feeling paranoid and repeatedly asked why. Reassurance was given. Discussed distraction techniques. They did not appear to be effective as Mr Everest states that he does not feel like doing anything. Denied current thought, plans or intent of deliberate self-harm. Described family as protective. Plan: daily RMN list. Distraction. Dr list. Miss Daisy, RMN, Nurse.
28/01/2014	Mental Health assessment. Pleasant. Engaged well. Good eye contact. Said woke up and thought had come through the other side'. Upset at the loss of his brother and will attend funeral on 03 February. Daily contact with mum and girlfriend and feels able to help by talking to them. Does not feel so absent-minded or agitated as had been. Concentration levels are better. Mood improved. Denied any current thoughts of suicide or self-harm. Plan: Weekly RMN follow-up. First one just after funeral. Mr Dahlia, RMN, Nurse
31/01/2014.	Met with Mr Everest with Miss Lupin, RMN, Nurse. Felt he was going mad. Explained symptoms. Said it was normal for this stage. He said he wanted to get funeral over with and start to move forwards. Mr Beech
02/02/2014	Seen in healthcare. Presented as low in mood, but relaxed. Spoke openly. No tearfulness. Described some paranoia, stating he had been overthinking things and worried that he had done something wrong due to the way his fellow inmates looked at him. Said he was a drug user in the community and experienced psychotic symptoms and visions under drugs. He was therefore concerned that these visions and thoughts he had had using drugs were real. He said due to support he had received by the PCMHT [Primary Care Mental Health Team] and counsellors, he was able to combat these thoughts and weigh up the pros and cons, giving him relief. Says he feels sad as he is going to funeral tomorrow. He does not feel he has grieved for his brother. Says his overall mood had improved and that things in his head he had been stressing about, he was able to rationalise. Plan: remain for RMN review. Miss Wisteria, Nurse.

03/02/2014	Person Escort Record form. Funeral escort. Risk indicator: Violence.
05/02/2014	Telephone call. Received a phone call asking if Mr Beech could go and see Mr Everest and his mother in Visits as both crying and Mr Everest's mental health was deteriorating. Explained he was a Substance Misuse worker and that Mr Everest had been seen by Mental Health. Mr Everest said he was now getting mental pictures of his daughter's head in his hands. Felt he was going round the bend and things were getting worse. Mrs Fuji said she would get the psychiatric report done for court from her solicitor. Mr Beech
06/02/2014	Received psychiatric report. Took it to Mental Health, said they would see him this week. Felt Mr Everest not suitable for current substance misuse work. Mr Beech
06/02/2014	NOMIS transfer report Mr Everest has been off work for 2 weeks since news of brother's death. Funeral was on 3rd February. He felt there was light at the end of the tunnel on 31/01/2014. Funeral set him back. Advised to attend work on the 5th but still off work. Miss Forth, PCO
07/02/2014	Said he felt horrible. Having frightening thoughts. Says he pictures himself as a serial killer. When asked to elaborate he pictures his head on a lizard's body; he is eating people. States he pictures himself holding his daughter's head, cut off her body and talking to it. Says he imagines a monster cowering over him. Says he feels scared and cannot understand why he is getting these thoughts. Says he has been experiencing nightmares for the past few weeks, but not mentioned them before. In the nightmares, people are putting bombs into the house and then men come and assault him and rape his children in front of him. Appeared lethargic. Asked if he was using substances on the wing. Denied this. Said he felt depressed but his mood had improved significantly, but had symptoms of anxiety. Not anxious all the time, but waking from these nightmares makes him anxious. Said he has had a drink and cigarette. Denies

palpitations and sweating. Had none of these issues before coming into prison. He said he attended his brother's funeral on Tuesday. Found it sad. Able to see the family. He cried, but did not feel he cried enough. Says he does not feel he has grieved properly. Continuing to see counsellors on a weekly basis. Says he is due to see doctor later this afternoon. Advised him to describe the symptoms. States the paranoia previously discussed has gone. Advised he will remain on follow up. Miss Wisteria, Nurse.

07/02/2014 Worried about anxiety. Always worries about things. Denied depression. Plan: discussed anxiety. Change mirtazapine to 30mg nocte [at night]. Dr Edelweiss GP.

08/02/2014 Seen by locum [Dr Edelweiss GP]. Prescribed mirtazapine 30mg nocte against the plan of Dr Tulip, GP. Dose not changed but to see Dr Tulip on Tuesday. Dr Carnation, GP.

11/02/2014 Happy with mirtazapine in the morning. Asked for increased dose. Lost his brother last week. Attended the funeral. Worried that he may start to have recurrence of voices like when he was using cocaine on the out. Dr Tulip, GP.

14/02/2014 20.47. Called to the wing. Mr Everest having anxiety attack. Sitting on the bed. Appeared upset. Kept going over past/present issues with personal life. Advised to do breathing exercise and to calm down and occupy mind. Eventually calmed down. Plan: spoke to wing staff to get him a job to help with anxiety. Miss Begonia, Nurse.

17/02/2014 19.55 NOMIS transfer record

Mr Everest asked me to contact mother after visit as worried about her, which I did. Miss Forth, PCO

No further entries until the period immediately prior to the self-harm incident. (See Chapter 4.)

OASys record

<u>Offending behaviour</u>

1. Number of court appearances: 10 under eighteen and 12 over eighteen.
2. Age at first contact with Police: 14. – 10/06/1999.

3. Number of convictions, cautions, reprimands, final warnings for violence: 1
4. Pattern as acquisitive crime is emerging.
5. Various disposals, including custody and community.
6. Analysis of offence:

   Offence committed 13/11/13.

   Burglary with intent to steal in dwelling.

   Sentenced at town 3 Crown Court 10/01/2014.
7. His previous offending committed with others. Current – was on his own.
8. Does not socialise often.

Drug Misuse:

1. First used cannabis at age 15. Not addicted. Helps him relax.
2. He first used cocaine aged 18. Used it four or five times a week. Last used the night before custody.
3. Addicted to painkillers. Taking 10 - 15 a day.
4. Assessed by Mr Beech, from CARATs. He does not feel ready to complete interventions to address substance misuse due to death of his brother. Said he would re-engage later.
5. Misuse linked to offending behaviour – Yes.

Emotional wellbeing:

1. Disclosed history of attempted suicide and self-harm. Cut his wrists 7 - 8 months ago. Trigger to this was his way of life, taking drugs and his relationship; did not expand on this.
2. Current thoughts – He said none.
3. Disclosed he felt low due to brother's death. He felt low due to the death of his brother, but said that the staff on the unit were helpful and understanding. Attended funeral 03/02/2014. Says he can access help. He can talk to the Chaplain, prison carers, unit staff and counsellor. Mr Elm.

3. He said he had been diagnosed with depression, had been on anti-depressants which have been prescribed for him at HMP Altcourse. He said he had a diagnosis of psychosis in August 2013. This has not been verified.
4. Since interviewed on 21/02/2014 he has been placed on ACCT.

Thinking and Behaviour:

1. Impulsive. Does not think of the consequences of his actions.

Attitudes:

1. He has several convictions. Previously supervised by Probation. He does have breaches of trust on record.
2. He arrived at HMP Altcourse on 06/12/2013. No issues about attitude or behaviour.
3. Standard level on the Incentives and Earned Privileges scheme, IEP. No adjudications. No negative entries in his file.

Risk:

1. With respect to risk of harm, risk to children is low; public: medium, known adult: low; staff: low; in the community low.
2. All risks low in custody.

Counselling notes, undated, Mr Elm

Session 1: Finding it hard to cope. Suffered panic attacks. Discussed breathing techniques and relaxation. He said he was angry about medication and the counsellor advised him to speak to the doctor. He was on the RMN waiting list. No current ideas of self-harm.

Session 2: He said his brother was in hospital critically ill and he was worried all the time and anxious about his mother. Talked about distracting, use of reading a book. He said he was not coping with medication and it was reiterated that he should speak to medical staff.

Session 3: His brother had died in hospital. He was pale, anxious and explained that he felt he did not know how to grieve. Discussed bereavement.

Session 4:	Talked about family support. He feels he needs to give them more support. He needed to change and needs time to get his head together.
Session 5:	The day after the funeral. He said he did not feel so anxious, but was more worried for his mum.
Session 6	Engaging well. Good eye contact. Wants to go to Cat D [Category D] or HMP Kennet [in Liverpool]. Says he thinks bereavement will hit him when he gets out of hospital.

Chapter 4 The events leading up to the incident of life-threatening self-harm on 22nd February 2014

21/02/2014	11.13 Attempted to engage Mr Everest. Denied any physical health issues. Mr Everest said he had been hearing a noise at night which he described as coming through the door. He was unable to elaborate. He says he believes he is being hypnotised again, but without further clarification. He believes someone is out to get him, indicating he had issues on the unit. He did not appear to be preoccupied during conversation, however did appear to be possibly under the influence of an unknown substance. Agreed to provide urine sample. To remain on daily RMN contact and an open ACCT. Miss Daffodil, RMN, nurse.
21/02/2014	14.25 ACCT opened. Miss Fir, ACCT assessor. Low mood, hearing voices.
21/02/2104	14.30 Concern and Keep Safe form and Immediate Action Plan Self harmed by cutting left arm after hearing voices. To stay in cell and see nurse. Mr Lune, PCO.
21/02/2014	14.54 NOMIS transfer report At 14.30 Mr Everest pressed buzzer. Thought it was odd as open cell. On entry said he couldn't cope and had cut arm. ACCT raised. Nurse attended and dressed wound.
21/02/2014	15.01 Medical record. Intentional self harm using razor blade. Wound cleaned. Tearful, unwilling to converse, one word answers. Stuff going on inside and outside prison. ACCT opened. Referral to RMN. Miss Petunia, RMN nurse.
21/02/2014	15.05 Self-Harm / Attempted Suicide form F213SH. Numerous small scratches to left forearm. Dressed. Miss Petunia, RMN nurse.
21/02/2014	15:03 ACCT entry Standing on corridor. Mr Ayr, PCO

21/02/2014	15:20 ACCT entry
	In cell with medical staff. Mr Ayr, PCO
21/02/2014	15:25 ACCT entry
	Asked how he was. Said he was hearing voices in his head. Said the voices were telling him that his family had been hypnotised. Said he speaks to Miss Scots Pine in OMU [Offender Management Unit] and she has undone the hypnosis. This stopped him hearing voices. Says he had a panic attack and cut his lower arm with a razor. Says he will not self-harm again and feels tired and drowsy. Poor interaction during conversation. Unable to maintain eye contact. Unable to fully concentrate. Mr Ayr, PCO
21/02/2014	16:05 ACCT entry
	In cell. Said his head is going round and cannot cope. Manager informed healthcare and ACCT assessor. Mr Ayr, PCO
21/02/2014	16:40 ACCT entry
	Speaking with ACCT assessor. Miss Severn, PCO
21/02/2014	16.55 ACCT Assessment
	Said he did not want to engage in the ACCT process. Refused to engage. He said he is hearing voices. Exhibiting erratic behaviour. Brother died on 22/01/2014. His behaviour has deteriorated since. Previous self-harm. Initial custody interview said he self-harmed last year due to depression. Already linked into RMN and CARATs. Not engaging in the assessment. RMN to attend case review and discuss option. Miss Fir ACCT assessor
21/02/2014	16:55 ACCT entry
	Taken to classroom with Miss Maple. Appeared to engage with her. Escorted back to cell. Mr Ayr, PCO
21/02/2014	17:05 ACCT entry
	Having dinner. Said he wanted out of this prison and wanted to go anywhere. Mr Ayr, PCO
21/02/2014	17:20 ACCT entry
	Filling canteen sheet Mr Ayr, PCO

21/02/2014	17:35 ACCT entry Laying on bunk. Mr Ayr, PCO
21/02/2014	17:36 ACCT entry ACCT handover. Miss Forth, PCO.
21/02/2014	17:45 ACCT entry Laying awake in bed. hands were over his face. Heard him say, "I don't want this". Miss Forth, PCO
21/02/2014	17:58 ACCT entry Pulled duvet against his face and shouted, "Take it down". Miss Forth, PCO.
21/02/2014	18.20 First ACCT case review Present: Mr Lune, PCO, Miss Lupin RMN, Mr Everest, Miss Fir (verbal contribution, not present) Discussed mental health issues. Agreed a lot of his problems due to Mr Everest previous drug misuse. Refer to Miss Rose, RMN, who specialises in mental health issues with people with drug misuse history. 5 x observation per hour day and night. Conversations day and night. Mr Lune, PCO
21/02./2014	18.20 care map Hearing voices. Action required. RMN intervention. Drug misuse: RMN intervention. Miss Rose, RMN. Mr Lune, PCO
21/02/2014	18:55 ACCT entry Lay on bed. Said, "Take it down". Mr Mersey, PCO
21/02/2014	19:00 ACCT entry Mr Everest pressed his emergency buzzer. He asked him to take down what had been placed on top of the door. Said it was a disc he used to monitor him whilst on an ACCT Plan. He appeared very paranoid at present. Told to relax. Miss Severn, PCO

Next entries note asleep or watching TV.

21/02/2014 20.50 ACCT entry

Sat on bed, hands on head. Mr Ganges, PCO

21/02/2014 21:34 ACCT entry

Lay under the covers reading a letter Mr Ganges, PCO

Next entries note that Mr Everest is either lying on bed or standing at the side of the bed.

21/02/2014 22.48 ACCT entry

Pacing around cells. Mr Ganges, PCO

21/02/2014 - 22/02/2014 ACCT entries

Monitored through the night. He was noted to be sitting up under the covers at 00:15, 01:15, 01:55 02:41, 03:14. Otherwise lying down under covers. Mr Ganges, PCO

22/02/14 07:15 ACCT entry

Sat in bed under covers, propped against the wall. Mr Euphrates, PCO

22/02/2014 07:45 ACCT entry

Laid in bed, awake. Head in hands. Mr Euphrates, PCO

22/02/2014 07.55 ACCT entry

Sat on bed, head in hands, awake. Mr Euphrates, PCO

Next few entries lying or sitting on bed

22/02/2014 08.59 ACCT entry

Walking very slowly along landing Mr Mersey, PCO

22/02/2014 09:15 ACCT entry

Standing in recess area waiting for meds. Acting strange, but looking at me at times. Miss Forth, PCO.

22/02/2014 09:23 ACCT entry

Said he was dying and that his body and head were in pain. Asking to go to healthcare. Miss Daffodil RMN stated she needed to speak to her superiors about it. Mr Everest would not leave the medical

room. Pressed first response button. Mr Everest stated, “Well get the team done”, when they stated they would have to do this. Escorted to his cell by first response team. Miss Forth, PCO.

22/02/2014	09:40 ACCT entry
	Pressing his buzzer saying he wants to come out. Manager has instructed that he stay behind door. Miss Forth, PCO.
22/02/2014	09:50 ACCT entry
	Louis Mr Everest on buzzer again Miss Forth, PCO.
22/02/2014	09.55 ACCT entry
	Medical assistance called. Cut up on his right forearm, 5 - 6 cuts. Miss Forth, PCO.
22/02/2014	10.05 ACCT entry
	Nurses attended Miss Forth, PCO.
22/02/2014	10.08 Medical records.
	During medication round he approached Miss Daffodil, RMN, Nurse, and asked to be taken into healthcare. He said, “My head is going. I just need to come to healthcare”. Unable to elaborate further, but kept repeating it. Did appear to be under the influence of unknown substance. Asked if he had been misusing anything. Denied. Explained need to do a urine sample. Asked him to return to the unit whilst I return to healthcare to discuss his request to relocate to healthcare with senior manager, Miss Orchid. Medical Assistance was called due to a self-harm incident involving Mr Everest
	Miss Daffodil, RMN, Nurse
22/02/2014	10:15 ACCT entry
	Informed that he was going to healthcare to have stitches. Miss Forth, PCO
22/02/2014	10.20 – 11.15 ACCT entry
	Entry states on constant observations. Signature unclear.
22/02/2014	10.42 Medical records
	Code called. [emergency call put out for healthcare staff]

Attended. Four straight lacerations to right forearm. Steri-stripped right forearm. Already on ACCT and RMN follow-up. Miss Rhododendron, Miss Rhododendron, Nurse.

22/02/2014 10.30 Self-Harm / Attempted Suicide F213SH form

Four straight lacerations to Right forearm

Miss Rhododendron, Nurse.

22/02/2014 10.58. Clarification of previous entry. Mr Everest was actually attending healthcare outpatient, having his forearm sutured following an act of self harm. He said he has currently got issues on the unit, but declined to elaborate further. Discussed that there was no bed space on healthcare, but stated that he had received the same support on the unit and that he would have daily RMN visits and also placed on counselling referral for bereavement support. Agreed for urine sample. Mr Everest is on an open ACCT. When asked to return to the unit by Mr Clyde, PCO, he refused. Miss Daffodil, RMN, Nurse spoke to covering Manager, Mr Ribble who agreed to attend healthcare to discuss current issues he may have on the unit. Mr Everest waiting to discuss further with unit manager under the supervision of Mr Clyde, PCO, Miss Daffodil, RMN, nurse

22/02/2014 11:25 ACCT entry

Arrived back with Mr Clyde, PCO. Extremely hesitant to come back to the unit. As he entered the foyer he tried to bolt. Restrained by Mr Mersey, PCO, and Mr Clyde, PCO, restrained him holding wrist and arms until first response team came. Arrived and escorted back to cell. Miss Forth, PCO

22/02/2014 11:45 ACCT entry

Instruction from Mr Tyne. He must stay behind his door because of odd, bizarre behaviour. Miss Forth, PCO

22/02/2014 11.49 Healthcare record

Due to on-going incidents this morning, to minimise risk, discussed with duty director, Mr Tyne, that Mr Everest remained behind his door due to his current presentation. However, I did explain I was not happy with this until further RMN assessment had been completed.

Therefore, I said I would like Mr Everest admitted to healthcare for on-going assessment. Miss Daffodil, RMN, nurse.

22/02/2014 11:50 ACCT entry

Asked if he wanted any dinner. He said he did not, but could he get him some skins. Told him he was going to healthcare. Mr Mersey, PCO

22/02/2014 11:52 ACCT entry

Tried to engage in conversation. No response. Mr Dee, PCO arrived to escort Mr Everest back to healthcare. Miss Forth, PCO

22/02/2014 11.59 Medical record

First response. Prisoner refusing to go back to the unit. Initially said that, but then changed his mind. No injuries. Miss Rhododendron Nurse

22/02/2014 12:10 ACCT entry

He did not want to go to healthcare. Started to wander, so was put back in his cell. He had taken TV off the shelf. It was taken out of the cell.

22/02/2014 12:30 ACCT entry

Escorted to healthcare Miss Forth, PCO

Next entries relate to him being placed in cell in Healthcare.

22/02.2014 13.08 medical record: admission to Healthcare centre

1. Observe, document and complete mental health assessment and identify appropriate treatment.

2. Monitor ideas of self-harm

admission by Dr Carnation Mr Dahlia, RMN, nurse

22/02/2014 13:22 ACCT entry

Denies any self-harm ideas. Mr Dahlia, RMN.

22/02/2014 13.44 ACCT entry

Walking along corridor Signature unclear

22/02/2014	13:55 ACCT entry
	Sitting on bed. Miss Thames, PCO
22/02/2014	14:05 ACCT entry
	Walking along corridor. Miss Thames, PCO
22/02/2014	14:15 ACCT entry
	In office. Speaking to staff. Miss Thames, PCO
22/02/2014	14:26 ACCT entry
	Walking along corridor. Miss Thames, PCO
22/02/2014	14:30. Concern and Keep Safe form, within ACCT. Mr Everest self-harmed by cutting his left arm after stating he heard voices. Mr Lune, PCO.
22/02/2014	14:35 Immediate Action Plan, within ACCT.
	Authorised to stay in single cell. If risk increases will relocate. Mr Lune, PCO.
22/02/2014	14:40 ACCT entry
	Speaking to Mr Clyde, PCO.
	Miss Thames, PCO
22/02/2014	14:50 ACCT entry
	In cell by bed. Miss Thames, PCO
22/02/2014	14:50 ACCT entry
	In cell by bed Miss Thames, PCO
22/02/2014	15.03 ACCT entry
	Standing in corridor Miss Poppy, RMN, Nurse
22/02/2014	15.20 NOMIS transfer record
	Said he did not want to return to unit. Denied bullying. Escorted back to unit. Discussed with
	Mr Tyne who said he should be admitted to healthcare. Mr Ribble

22/02/2014 15.53 Healthcare record

At 15.15 went to observe Mr Everest in his cell. Sitting at a table making a cigarette. About to return to the nurse station, but asked Mr Everest if he would like to talk as he was on daily RMN intervention. When entering the cell, it was evident that he had a noose around his neck, which was attached to the cell window. Raised Code 1. [Code 1 is an emergency call for assistance.] Ran to the nurse station to alert Miss Thames, PCO. Myself and Miss Thames, PCO, then proceeded to cut him down by lifting him, loosening the grip to enable Miss Thames, PCO, to release him from the noose. He was breathing, placed in the recovery position. RGN, Miss Lilly, RGN, arrived at the scene, instructed to proceed with CPR [cardio-pulmonary resuscitation]. Dr Carnation GP inserted a cannula [tube inserted into blood vessel] and oxygen given. CPR continued until paramedics arrived. He was taken to hospital. Miss Poppy, RMN, Nurse [Cardiopulmonary resuscitation.

The administration of life-saving measures to a person who has suffered a cardiac arrest. A person in cardiac arrest is not breathing and has no detectable pulse or heartbeat.]

22/02/2014 19.51 NOMIS transfer report

At 09.15 Mr Everest came for medication in a very strange manner with arms outstretched as if carrying something. Refused medication and asked if he could go to healthcare. Miss Daffodil, RMN, said he needed to return to the unit but he refused. "I tried to usher him out but had to make response call as refused. First response ushered him back to cell. He was acting strange and saying no no no. As observations continued, around 09.55 he cut up-5/6 cuts, medical assistance was called and wounds dressed. He attended healthcare for stitching. On his return Mr Clyde, PCO, asked for assistance as Mr Everest hesitant in returning to unit. Ushered in by two officers and became hesitant, saying no, no, no tried to get out and bashed into a wall. I tried to get one arm, ended up outside on concrete ramp and Mr Everest sitting on the ground. First response attended and he went back to the cell. Mr Tyne said to keep him behind the door for his own safety. 11.45, on checking on Mr Everest, he had taken TV

off wall and saying no, no, no. Escort to healthcare arrived and he refused but was then persuaded. Miss Forth, PCO

22/02/2014 unknown time. Mental Health referral

Mr Everest presenting very odd and bizarre behaviour at a.m. medication. Refused his medication. Said, “I'm dying. It's my head. It's in my head”. Miss Daffodil, RMN instructed him to return to his cell. His behaviour led to a first response being called. Shied away from Miss Forth, PCO. Said, “No, no”. Throughout the day continued to behaviour in this manner. Slow movements. Walking with head down into shoulders and with his arms held out, then hiding behind his hand, waiting to get medication. Miss Forth, PCO

23/02/2014 10.33

At 15.20 attended Code 1. Inmate lying on the floor, breathing, but unconscious. Glasgow Coma Score of 3. [The Glasgow coma scale is composed of three tests: eye, verbal and motor responses. The lowest possible GCS is 3 (deep coma or death), while the highest is 15 (fully awake person).]

Ambulance had been called. Incontinent of urine. Oxygen therapy initiated. SATS [oxygen saturation in the blood] and BP [Blood Pressure] good. He had been cut down from a ligature made of bed sheets at 15.15 from a ligature point at the window. Instructed Miss Poppy to stabilise his neck. Inserted cannula into his left hand. Breathing was laboured and grunting in nature. Pupils fixed at 3 mm. Dr Carnation, GP.

22/02/2014 unknown time Mental Health ACCT Referral Form

Presenting very odd and bizarre behaviour at am medication. Stated ‘I'm dying’’ it's my head. It's my head. Would not return to cell. First response [emergency call] shied away from me saying ’no, no’ Continued like this all day. Slow movements, walking with head down with arms held out as if carrying a huge object under each arm, then hiding behind hand whilst waiting to get medication. Miss Forth, PCO, Prison Officer

22/02/2014	Unknown time. Mental Health referral form Have received a phone call from mother and spoken to staff. Mr Everest in need of RMN intervention. Being seen by psychiatrist in community Mr Esk Prison Officer

Chapter 5 Post-incident records

Prison Healthcare entries

22/02/2014	17.56 Contacted Hospital 2, [in city 1]. Advised that he had had a CT scan and was being transferred to ITU [Intensive Treatment Unit]. Changes suggestive of brain damage. Miss Orchid, nurse.
23/02/2014	Telephone call to ITU. Medically induced coma. Mr Posy Healthcare assistant
24/02/2014	Telephone call to ITU. Unconscious but breathing unaided Miss Amaryllis nurse
25/02/2014	Telephone call to ITU. Staff Nurse said Mr Everest had required further sedation as there had been concerns over seizures. Not sedated at this time. Staff attempting to wake him later. Miss Clematis, RMN, nurse.
25/02/2014	19.47. Telephone call to ICU [Intensive Care Unit]. Still sedated and ventilated. Miss Clematis, RMN, nurse.
26/02/2014	Visited ICU. Spoke to one of the staff nurses. Mr Everest remains on the ventilator. Been having unexpected seizures Miss Amaryllis nurse
27/02/2014	Mr Everest unresponsive. Continues to be on the ventilator. Hypoxic brain injury, but severity is unknown at this time. Miss Orchid, Nurse. Staff contacted the General hospital on a daily basis. I will only note entries of relevance below.
07/03/2014	Spoke to Staff Nurse. Trauma ward at Hospital 1. Admitted on 05/03. Reported Mr Everest is unresponsive and not for resuscitation. Still having seizures. Miss Poppy, RMN, Nurse.
09/03/2014	Hospital 2 said he was going to be assessed, as he is having seizures. Staff contacted the ward on a daily basis. Miss Sunflower Nurse.
23/03/2014	Mr Everest is improved. Making noises, although not appearing to want to talk, but is recognising friends and family. DNR [Do not

resuscitate order] has been removed. Seizures reduced. Awaiting rehabilitation bed.

04/04/2014	Attended the neuro-rehabilitation unit to discuss the care of Mr Everest. Spoke to Mr Gardenia nurse who said he has a hypoxic brain injury. He has cerebral [brain] irritation and is agitated. He is being peg fed. He had a twelve-week plan with a review after four. [Percutaneous endoscopic gastrostomy (PEG) is a procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate] No seizures. He said he would not be able to jump out of bed and that there was a 12 week plan with review every 4 weeks. Suggested no need to ring every day. Miss Lotus, Senior Nurse
05/05/2014	Mr Everest has been on the neuro-rehabilitation ward since 24 March 2014. On 04 April he was nursed in bed only and fed via a peg. The care plan was for him to have extensive treatment for twelve weeks. He is unable to get from bed to chair unaided. He still had some involuntary movements of his arms and legs. Miss Amaryllis
12/06/2014	Received call from Mr Gardenia, Ward Manager, to say that Mr Everest will be transferred to the Specialised Rehabilitation Unit on 18/06/2014 which is in the grounds of Hospital 3 [in town 4, county 2], slow stream rehabilitation. Miss Anemone Nurse
13/06/2014	Early release on compassionate grounds Criminal Justice Act, Miss Oak

Medical entries, hospital and community

16/04/2014	Hospital 1 [in city 1] 22 February 2014, discharged to Hospital 4 [a hospital in city 1 with specialist neurology facilities] on 24 March 2014 and to Hospital 3 on 23 June 2014. He was found hanged on 22 February 2014, the hanging was believed to have been between 10 and 12 minutes. He was transferred to Hospital 1 with a Glasgow Coma Scale score of 5 out of 15. He was intubated and gradually weaned and extubated. He suffered from hospital-acquired pneumonia on 23 February; he was stepped-down to the ward on 5 March 2014 from High Intensity. He developed myoclonic jerks on 10

	March and was prescribed Levetiracetam. He was also found to sustain a wound in his right forearm thought to be from glass. It was reviewed by the plastic surgeons. He was transferred to the NRU [neuro-rehabilitation unit] on 24 March and he developed an ear infection, he was initially incontinent but then had a period of self-catheterisation but then became continent. Dr Heather Speciality doctor.
8/05/2014	He has an extensive past psychiatric history with previous input from early intervention and community mental health team. There was a history of moderate depressive episodes with occasional psychotic symptom, harmful use of cocaine. Prior to prison treated with mirtazapine and quetiapine. In prison his mood dropped. He cut his arms and subsequently hung himself. Transferred to Hospital 1 Trauma Unit. He had typical symptoms of anoxic brain injury. He is fully dependent on nursing care for all his activities of daily living. He cannot walk. He is confused, with problems of short term memory and speech. He has some behavioural problems, agitation and hyper emotionality. He requires use of urinary catheter and pads. He has a PEG tube. The likely prognosis is poor. He will spend the rest of his life in care. Dr Crocus, consultant neuropsychiatrist
26/11/2014	GP records Telephone encounter with Dr Frangipan from Hospital 3 Rehabilitation Unit. Mr Everest has significant cognitive and physical impairment and felt not to have capacity to make decisions. Making some progress at Hospital 3, but no real progress with independence. During his stay at Hospital 3 there was lots of family distress, but staff developed a good relationship with the family. The situation with the family broke down at community health and/or substance misuse facility 3 [a specialist neurorehabilitation centre in city 1 for people with acquired brain injury and complex needs] with mum focusing on him being wet and the state of the toilets and she had self-discharged Mr Everest and taken him home. Mr Everest is a vulnerable adult and lacks capacity. He has been taken home where the situation is not set up to cope with his needs. Concerned that he will need heavy psychological input to reach his full rehabilitation potential.

The other entries until the end of December 2014 related to referrals for physiotherapy and some problems with chest infections.

Entries throughout 2015 by the GP relate to physiotherapy, speech and language therapy. Also noted poor short-term memory. Mr Everest was discharged from ward 8 on 1 June 2015.

05/03/15 Dr Frangipan Impairment global memory attention and executive function difficulties, limb ataxia, dysarthric speech, no swallowing difficulties, previous behavioural issues. Requires propelled wheelchair. Requires assistance of two for transfers. Requires assistance for personal care and domestic tasks. Requires 24-hour care. In the history she said there was an attempted hanging in February 2014, leading to hypoxic ischaemic brain damage. Required ITU, stepped down to ward level, spent the next eight months with the county 1 and county 2 Rehabilitation Network, starting on the Hyperacute Rehabilitation Unit [at Hospital 4]. Moving to the Complex Rehabilitation Unit at Hospital 4 and to the Specialist Rehabilitation Unit at Hospital 3 in June 2014. [The Specialist Rehabilitation Unit at Hospital 3 cares for patients who have experienced severe, life-changing injury or illness. It is at Hospital 3.] He has worked with the multi-disciplinary team. He requires a wheelchair for mobility. He has moderate to severe speech ataxia. Mrs Fuji moved Mr Everest from community health and/or substance misuse facility 3 nine days after his admission. She was concerned about care and cleanliness there. His mother asked for support from the GP and Social Services. In a meeting with Dr Frangipan and Dr Crocus with Mrs Fuji and Mr Everest she said that since he has been home his partner has not visited him and she continues to allow the children to spend time with Mr Everest. She said he sleeps downstairs in the lounge on a hospital bed. Mum is a full-time carer. He wakes her a few times per night to empty his bladder. Mrs Fuji's sister provides additional care. An OT [occupational therapist] has shown Mrs Fuji how to transfer Mr Everest and she has been able to

	undertake these alone. There have been no episodes of challenging behaviour. He has myoclonic jerks. She feels his speech is improving and his legs are stronger.
02/06/15	In a letter from Dr Frangipan she said that he was started on the amisulpride to manage behavioural difficulties following hypoxic ischaemic brain injury. There was some confusion over dosage. Last week he changed and became more agitated, not sleeping, appeared to be hallucinating, thinking there was a fire and was paranoid, would not drink anything unless someone else tried it first in case he is poisoned. He feels his bottom is burning and attempts to stand up to relieve it. He suffered a fall yesterday. Dr Frangipan felt that the symptoms have appeared because of a reduction in his amisulpride which was rectified.
08/06/15	Mr Everest was reviewed by Dr Thistle. He suggested that he continue on amisulpride and did not need any further anti-psychotics. He was having sleep disturbance. Dr Thistle therefore suggested Zopiclone and to have a review by neurology.
22/10/2015	Dr Frangipan Consultant Rehabilitation Medicine:- It was felt that fire-smelling was not epileptic in origin. Mr Everest was kept under review. When seen on 9th September 2015 by Dr Gypsophila, Consultant Neuropsychiatrist, Mr Everest complained of episodes of feeling he was on fire. These had not really improved on amisulpride. Dr Gypsophila queried epilepsy. He had already been started on sodium valproate and also Epilim. Dr Gypsophila summarised Mr Everest's difficulties when he reviewed him in the clinic on 20 August 2015. He had no psychotic symptoms apart from smelling burning. He had myoclonic jerks. He also had no problems with his mood and no ideas of self-harm or harming others. Family reported that he was happy. He was reviewed on 02 July 2015 by Dr Frangipan, Consultant Rehabilitation Medicine, who reported he had significant cognitive problems, but felt that he was doing better at home, interacting well with the family. [Cognition refers to thinking and conscious mental processes.]
24/11/15	Mr Everest was assessed by Dr Gypsophila, Consultant Neuropsychiatrist, at the Brain Injury Rehabilitation Unit and

discharged back to the GP. He was not experiencing any thoughts of self-harm or hallucinations. He appeared quite cheerful. He, at times, felt he could smell fire and the feeling that he was on fire. He was using Zopiclone to good effect.

11/02/2016 Letter from Community Specialist Rehabilitation Service:- He was discharged from this service on 4 February 2016. Care is provided by his mother at home. He requires assistance in all activities of daily living. Occupational Therapy has optimised visual compensation strategies. He has been unsettled at night. He has been having physiotherapy since April 2015. The focus of his psychological intervention has been supporting his mother and aunt to create a routine and structure to Mr Everest's day. He enjoys the daily activity. Joint intervention was planned between OT and psychology to help him to sleep alone, but because he was unsettled, calling out a lot to his mother, asking about his children, asking about the reason he is in a wheelchair Mrs Fuji has been advised to write down the answer to these questions on a card and refer Mr Everest to them when he asks the question. He believes he can smell fire when in bed. Strategies for managing this have been discussed. He has been referred to the Sleep clinic. Dr Azalea Clinical Psychologist, Miss Cornflower Physiotherapist, Miss Cyclamen Occupational Therapist.

Chapter 6 Themes from interviews with staff and family

Factual issues from staff interviews regarding care of Mr Everest

Miss Poppy, RMN:

She said that Mr Everest deteriorated when his brother died. He was despairing, beating himself up. She said the children were protective. He had no suicidal ideas. She asked him daily. He never looked under the influence of drugs. No psychosis observed at any point.

Last time she saw him was twenty past one [on 22nd February 2014]. He was preoccupied about tobacco. There were six or seven other people on ACCTs at the same time.

Miss Daisy, RMN:

She described Mr Everest as low in mood, anxious, flat and unkempt. He was much better on mirtazapine. He had no suicidal ideas or psychosis. She heard drugs had been queried, but did not see him under the influence. She was shocked when he harmed himself as there were so many protective factors.

Miss Iris, RGN:

She did not remember Mr Everest as she only saw him briefly. She commented that the GP would check if a prisoner was on medication and, in the case of antidepressants, prescribe. She noted that the view from prisoners was that mirtazapine was more sedative. She also noted a change in presentation of prisoners with legal highs around this time, they were aggressive with changes to their physical health.

Miss Severn, PCO:

He [Mr Everest] was very quiet. He had lots of family issues and problems with his medication. She described Mr Everest as frustrated and not manipulative at all. Towards the end he was incoherent, odd, sitting rambling in his cell. She

thought he needed to see someone. She put a referral in writing. She felt he had underlying issues. She did not think that legal highs played a part.

Miss Daffodil, RMN:

On 22nd [February 2014] doing a meds [medications] round on Foinavon. Mr Everest approached the clinic and said, "Take me to Healthcare. My head's going". She queried whether he was under the influence [of drugs]. He denied this. She asked for a urine sample. He refused to go back to the cell. She went to discuss him with a senior nurse. They decided he should go to Healthcare. She came back and he had self-harmed. He went to outpatients for suturing. There were no beds on Healthcare. She said he would get the same level of support on the unit with daily RMN counselling. He refused to leave Healthcare. She said Mr Tyne said he should go behind his door. She was not happy with his decision. She thought maybe Mr Tyne was concerned about drug-taking. She felt Mr Everest needed more assessment. She said that a urine sample result would not have come back straight away. She thought there was no need for constant observations in Mr Everest's case. She said that constant observations were for people who definitely stated that they wanted to die.

Dr Tulip:

When Dr Tulip first saw Mr Everest he was agitated, concerned about medication, worried what he would be like without it and that he may hear voices. He wondered why someone so agitated was not on an SSRI [Selective Serotonin Re-uptake Inhibitor] as first-line drug [for the treatment of depression]. Dr Tulip could not recall if he had summary at the first appointment [from Mr Everest's GP in the community] but the summary showed Mr Everest had been on various antidepressants for years, including SSRIs; amitriptyline and latterly mirtazapine. He found Mr Everest to be not clinically-depressed, just agitated. Suggested SSRI. Mr Everest was reluctant, but agreed. Dr Tulip said he was also seeing an RMN who would have been doing drug therapy (did not know that for sure).

Dr Tulip's concerns about mirtazapine were because when he first started working in prisons, drug addicts wanted mirtazapine for sedation. It was used inappropriately and there was an increased use of it. He wrote to the Head of Prison Healthcare. He received a reply telling him not to use mirtazapine. This was in 2007/2008. Also RGCP guidelines for prison express concerns about mirtazapine. He does not know if Mr Everest took sertraline as they had paper

prescriptions at that time. When reviewed, Mr Everest was still agitated and wanted an increase in mirtazapine. He prescribed 30 mg initially.

Dr Tulip said many prisoners say they are depressed. He said that he asks them about symptoms and treatment. He does not use PHQ [Patient Health Questionnaire (PHQ9)]. He also does not use it in the community [he also worked in a practice in the community]. He said that he looks at what they look like and looks at records and establishes whether they are using drugs et cetera. Apart from length of time the person has had symptoms, he looks at symptoms, overdose, protective factors. He said that self-harm threats can be manipulative sometimes. He said that he did not explore self-harm with Mr Everest as more concerned about agitation. He did not think he was clinically-depressed.

He said he looks at the Reception screen and looks at SystmOne, but they are not very user-friendly. When he gets the GP summary from the community he checks if medications are appropriate. He would often ring the GP for clarification. He did not know the reason for Mr Everest's agitation. He did not know why. He said that Mr Everest was not aggressive.

Miss Oak:

She saw Mr Everest on remand for a court report at the beginning of this prison term. He was low in mood, weepy. She spoke with prison staff as she was worried about him. He said there was a psychiatric report previously prepared on him. His mum phoned her. Mum said that the prison were not speaking to her. She spoke to Mum twice. She was concerned about his medication. Miss Oak told the prison to pass this on. She said she was concerned enough to do this. She said he was not normal, but not psychotic. He could not focus. He was not worried about going back to jail. He did not come across as a drug-user; more mental health problems. She said she did more than usual with him as she spoke to the prison about mum and her concerns. She said it would be useful for Probation to have a mental health history available when they are doing reports. She did not have access to the psychiatric report.

Mr Ribble, Prison Officer:

Mr Everest was seen on 22nd February. He did not want to return to Foinavon Unit. He was not aggressive but did not give a reason, which was very odd. Mr Ribble did not know him before. Another manager and Mr Ribble persuaded him to walk back. He did not require any force. Discussed with Mr Tyne, Duty

Director. He told Mr Tyne Mr Everest was a bit strange and that there was no reason why he did not want to go to the wing. Mr Everest later moved to Healthcare, at dinnertime. Mr Ribble said he may have taken him to Healthcare; he could not remember. There was no indication of drugs. Mr Ribble had had mental health training; he felt there should be more.

Mr Ash, Chaplain:

His first contact with Mr Everest was when his mum rang and Mr Matterhorn [Mr Everest's older brother] was in hospital. Mum said, "Keep an eye on him". He spoke to the hospital. On 22 January Mr Matterhorn died. Mr Ash told the Wing Manager and Duty Director. He then met the Manager and told Mr Everest. Mr Everest was very stressed and emotional. He was animated more than low.

On 24/01, he wanted Mum to have a compassionate visit as he was concerned about Mr Everest. He asked another chaplain to join them which was unusual but he did this as they were both very emotional [Mr Everest and Mrs Fuji]. He was worried that they were vulnerable. Mrs Fuji was upset and concerned about Mr Everest. On 27/01, Mr Everest was seen by another chaplain. On 30/01, he asked to see the chaplain. The next time Mr Ash saw Mr Everest was when he was in hospital. Mum phoned a number of times; he could not recall the content of the telephone conversations. In hospital after the incident, Mum was angry. She said that G4S had not looked after him. Mr Ash tried to get her to focus on the family. Mr Everest never attended the Chaplaincy.

Mr Lune, PCO:

He said that Mr Everest presented with low mood and was difficult to motivate, but flat. He saw him when prison staff or CARATs expressed concern about him. He said Mr Everest had not seen his kids and was all doom and gloom. Mr Lune, PCO, asked him about self-harm. He felt that Mr Everest's kids were protective and he did not think Mr Everest was suicidal. Mr Everest was placed on an ACCT on 21 February. Mr Everest met Miss Fir. He would not engage in the assessment. He did ACCT Keep Safe form. Mr Lune, PCO, set up the review with Miss Lupin, RMN, but Mr Everest would not come out for review. They were concerned he was lower in mood and that his brother dying had been a trigger. Mr Everest was fearful. They kept him on five observations an hour. Mr Lune, PCO, said he normally tries to reduce it as observations are intrusive. He said if somebody is at risk of self-harm, he always puts them on an ACCT. Miss Lupin,

RMN, thought Mr Everest should stay on the wing. He asked Mr Everest about self-harm. Mr Everest was quite solitary but had been no trouble on the wing. He liked being in a single cell. He did not want to work. He liked to be locked up. Mr Lune, PCO, said that he had a personal approach and can normally lift people.

Miss Thames, PCO:

She is responsible for running the prison regime in Healthcare. Healthcare has twelve beds. They are all single cells except cell number 11 which is a two-bed cell and cell number 12 which is a care suite and has a carer who stays in it with the prisoner. Mr Everest was admitted to Healthcare. He asked her if she could get tobacco for him. She asked another officer. This was around the time of the lunchtime lock-up, but she still did his observations. When they were unlocked she took the boys to the yard. This was around half one to two. She asked Mr Everest to come out. He said, "No, thanks". The nurse was doing the observations while she was out on the yard. She was out on the yard for 10 -15 minutes. She did not stay longer as she was aware it was a new nurse. She took her coat off and then the nurse knocked on the window and she ran in and Mr Everest was hanging. She went in with scissors, made a radio call for the ambulance. The medical team came in a minute.

She said that the nurse pressed the first response. She cut Mr Everest down with scissors while Miss Poppy, RMN, took the weight. She thought he was dead because he was blue, but he was breathing. Someone said, "There's a pulse". She said everyone has a fish knife [a type of knife that can be used as a cut-down tool], but she used scissors as it was better to cut people down.

She said there were a few people on observations. She said Mr Everest looked a bit down. She said no bizarre behaviour was witnessed. She did not know why he was there. There had been a first response call in the morning. She did not know anything from handover, as it was only brief. She said she does not delve into medical issues as she is an officer. She said usually after about a week she would know more, particularly if they were on an ACCT.

She said that the observations were done five times an hour, irregularly. She said Mr Everest took his chance when she took the other lads to the yard. She has had some mental health training, but not much; she has learned on the job. She said Mr Everest was genuine.

Post-incident, her Senior Manager said that she could go home.

Mr Tyne, Duty Director:

He described that he had heard that Mr Everest was exhibiting erratic, bizarre behaviour and that he did not appear well or stable. He saw Mr Everest; he asked for him to be seen by an RMN. Mr Everest was not being awkward, he was unwell. He had not previously been on Mr Tyne's radar but "alarm bells" rang in his head that day [due to his concerns about Mr Everest]. He was not settled, not conforming, agitated and up and down. He was reluctant to go back to unit but did not say why. Initially Mr Tyne thought it could be related to drugs but then dismissed this.

He thinks that initially there was no available beds on Healthcare. He said that he insisted that the staff in Healthcare try and accommodate him and virtually instructed them to do so and was quite stern which does not happen often. He [Mr Everest] had moved to Healthcare by 12.30 lock-down and he was automatically on five observations per hour.

Mr Tyne went to the unit. He cannot remember whether Mr Everest was still there. He said that the staff were upset after the Safer Custody investigation [into the incident]. He does not remember saying Mr Everest should be put behind doors.

Mr Beech:

He went through his entries as documented in section 4 of this report.

He stressed that Mrs Fuji was trying to get his [Mr Everest's] mental health sorted out. She said she could talk to Mr Beech. He did not think that Mum was unhelpful. He said that he closed the case as it was more of a Mental Health problem not Substance Misuse. After that, he periodically asked how Mr Everest was. Mr Everest had been referred to Substance Misuse following his reception into prison. He said he had a good rapport with Mr Everest. He was not surprised at what Mr Everest did as he was so agitated. He said, however, that Mr Everest had always denied ideas of self-harm.

He said that the prison previously had a dual-diagnosis nurse but he is not sure if Mr Everest was referred.

Miss Lupin, RMN:

She did not do the initial assessment on Mr Everest, but picked up the referral. When he was first assessed, he said that he was seeing a psychiatrist in the community, he was worried about his medication. There was not much evidence of low mood, more anxiety about coming into prison and not receiving input. He seemed to respond to support. He was booked in with a GP in the first two weeks. He was offered alternative medication by the GP. He presented with increased anxiety and low mood. He was placed on daily intervention. She saw him twice in that period. She provided reassurance, she checked he was not going lower in mood and she referred him to CARATs. The next two times she saw him he was quite low and anxious about his meds [medication]. He was prescribed the meds, but at the wrong time of day. He was quite dependent on the Mental Health team and quite reclusive. He did not want to go to work and asked for a sick note, but was encouraged to go. She asked about self-harm regularly.

She did not see Mr Everest after this period but sometimes bumped into him. He was worried about the risk of low mood and fixated on the fact that his mood may drop. He was on ACCT. She wondered if he was taking drugs as his presentation changed so much. He was discussing different things and there was a rapid decline, with auditory and visual hallucinations. She did not see him like this but just discussed the case with her colleagues.

She thought they [the Mental Health Team] had enough information about his case. She had seen many like him who did not get their meds prescribed. She has seen many people taking legal highs and they deteriorate rapidly. They would not have referred him to a dual-diagnosis nurse as he was not saying he had a substance misuse problem. She said that serious mental health concerns are referred to In-reach. [Mental Health In-Reach Team. A team providing services for people with severe mental illness.] Mr Everest had depression, therefore he was not suitable for them.

Miss Rose, RMN:

Miss Rose, RMN, indicated that her contact with Mr Everest had been minimal. She described that Dr Tulip refused to prescribe medication initially but then Mr Everest received this medication.

Mr Elm, Counsellor:

He described the six sessions as documented in section 3 [of this report].

He said that he usually gets referrals from staff, but also prisoners can refer themselves. He said sometimes he did not have the full session with Mr Everest. Sometimes he did not want to sit through the session as he found it difficult to deal with. The last time he saw him he was quite positive. He wanted to go to Cat D [a Category D prison]. He was talking about the future. He (Mr Elm) went on holiday and when he came back Mr Everest had self-harmed. He could not remember whether he had been referred from Healthcare initially. He said Mr Everest had panic attacks, he was struggling with being away from the family and he was quite low. He took a history in the 'here and now'. He did not talk about previous mental health or self-harm and he does not normally routinely ask about this.

He was really shocked when Mr Everest self-harmed. In the last session Mr Everest talked about Cat D, wanting to move forward. Mr Elm had planned to see him when he got back from leave. He said he usually does six sessions.

Mr Elm is employed by G4S. He specialises in trauma. He said 80% of prisoners have trauma. Mr Elm said that there is not enough counselling available [in prisons]. He said that the counsellors see a lot of people who self-harm. He said that trauma underlies a lot of self-harm and re-offending. He has supervision monthly.

Miss Fir, ACCT Assessor and Librarian:

She sees about two ACCT assessments per week. She said that since the incident with Mr Everest she now evaluates her practice more, but there is no formal mechanism for supervision. She went to see him, did her preamble. She said he was very distressed and would not sign the consent. He said that he could not see any point in engaging. She said this was on a Thursday. On Friday, when she knew there was a first response, she knew it would be him. She said he was despairing, full of grief, no hope and that his brother had died. When she heard Code Red, she knew it was him. She said, "When they are like him, no matter, that is what they will do". [Code Red is a radio request for emergency response from staff, usually when there is blood or burns.]

She sees lots of ACCTs, but occasionally comes across a prisoner like this. She said she has about five per year. She sometimes goes to the review, but not

usually due to time constraints. She will speak to the manager after assessing, either face to face or on the phone. She did not speak to the manager in this case. She said that Mr Everest did not engage at all and wanted to die. Mr Ayr, PCO, an officer, was sitting in on her interview. She felt a bit constrained by this but on balance felt that this did not significantly affect engagement.

Themes regarding care provision from staff interviews

Provision of medication on reception

Several staff said that it was usual for GPs to stop drugs and re-prescribe when they had checked community GP records.

Constant observations

Several staff said that constant observations were rarely used but that there would be no problems with it being agreed if staff thought it necessary. It was not considered in Mr Everest's case. Mr Tyne said that they do two per year for people who are constantly self-harming and not engaging. He said that he encourages staff to have conversations on observations and therefore prefers intermittent observations.

Staffing

Staff described a good team with good communication between healthcare staff and officers. They said that Foinavon was a good, relaxed and quiet wing.

Family contact

Some staff reported that Mum was ringing, but not to the wing, it was usually via Safer Custody. Most staff reported that they had no contact with Mr Everest's family.

ACCT reviews

Miss Avon said that they do monthly quality checks at the regular monthly meeting and also regular audits. They had not found any major issues with the ACCT process. There were minor errors, for example, people had not signed their entries, etc. She felt they were good at the process and had good quality conversations. She was asked about HMCIP criticism of their violence-reduction processes.* She said that this was now better. [*Report on an unannounced

inspection of HMP Altcourse by HM Chief Inspector of Prisons 9 – 20 June 2014, page 11, S5; pages 21 & 22; p. 60 (5.9 and 5.10).]

HMCIP had also said that there were a lot of ACCTs. [Ref. HMCIP report (as above), p. 12, S6] She said their default position was to be cautious. The default observations are five per hour until assessed, then drop to two. For constant watch, the Deputy Governor has to agree. They have some special cells, cell 8 on Healthcare is a constant observation cell. There is another one on the wing.

Several staff commented that ACCT reviews generally have RMN attendance and that people on ACCT get mental health input if needed.

Mental Health provision

Several staff said that the crisis RMN support which Mr Everest experienced was a good system, although patients would not see the same nurse every day. Nurses did not have their own case loads and some staff thought that this would be good. Several staff reported that more psychiatric input would be useful. One psychiatrist worked in Primary Care, one in In-Reach and both did a weekly session.

The GP did not meet up with the Mental Health team. The GP had done previously in another prison and anyone they were concerned about was discussed. The GP said that there should be more time to review patients with the Mental Health team.

Chaplaincy

Chaplains make a note of who they see in the Chaplaincy diary. The notes are basic; for example, it will only say “seen for a quarter of an hour”, with no description of the content of the meeting unless there is a big concern, in which case the Chaplains would tell the manager or open an ACCT. Sometimes there may be a more specific entry, for example “seen about bereavement”. The Chaplain said that sometimes he does not record anything at all if busy. The Chaplains do not have a case load. They have yearly ACCT training but no mental health awareness training. They do not attend specific multi-disciplinary meetings except ACCT reviews but do not attend all ACCT reviews.

Peer supporters

At HMP Altcourse prisoners trained to provide support to other prisoners are called carers. (In some other prisons they are called Listeners. Carers and Listeners are different as Listeners are trained by the Samaritans whereas carers are not. Carers are placed mainly with people with mental health problems. There was a carer suite in Healthcare and another care suite on the wings, which had not been used for a while.

Substance misuse

One staff member said that mental health staff do not always feed back to Substance Misuse staff. Substance Misuse staff write in SystmOne, but also have a paper file. There were no joint meetings between Substance Misuse and Mental Health staff. The Substance Misuse team had a case load and worked in geographical areas and also linked to community services on discharge.

Counsellors

The counsellor indicated that they do not work closely with Mental Health staff. He said that there should be a better system with formal referrals and that meetings with Mental Health would be useful.

Information from Mrs Fuji, Mr Everest's mother

Letter, undated

In her letter to me, Mrs Fuji queried why Mr Everest was not seen by a psychiatrist after the psychiatric report was faxed in early February.

Interview with Mrs Fuji

She said that on the 5th December Mr Everest went into custody and he phoned her to say he was sorry. He phoned a couple of days later crying. He mentioned cocaine and said that now he was in prison he could sort his head out. He said he needed his medication but the doctor said he couldn't have it. He said it was terrible in the prison.

He rang three to four times a day, crying, saying that they would not let him see the doctor. He eventually saw him but he did not prescribe mirtazapine. He asked her to go to the surgery and see whether they had a fax from the prison.

She went to the GP but there was no fax requesting information. She returned again but there was still no fax.

Mrs Fuji started to phone the prison. She rang three to four times per day. She talked to different people – but was fobbed off and never put through to Healthcare. She was put through to the Chaplain at times. She turned her house over, trying to find some information demonstrating that he was on mirtazapine. She eventually found a letter from the psychiatrist and faxed it to the prison on 6th February 2014.

Mrs Fuji said that when she visited him he was crying and that he rang frequently and that sometimes when he ran out of credit, the officers would let him ring.

When Mr Matterhorn [Mr Everest's older brother] went into hospital, Mr Everest was allowed to ring. When he deteriorated, Mr Everest went to see him with two officers and cried. He [Mr Everest] was handcuffed. When Mr Matterhorn died, Mrs Fuji went to see Mr Everest and Mr Beech and Mr Ash were present.

Mr Everest continued to phone daily, crying, and was still upset as he was on the wrong dose of mirtazapine – only 15mg. He phoned a couple of nights before the funeral and said, "Our kid's in the cell". Mrs Fuji spoke to the prison and told them he was not right but was not put through to Healthcare.

Mr Everest did not speak to anyone at Mr Matterhorn's funeral as Mrs Fuji thought that 'his head was gone'. The prison officers who accompanied him said, "he's not right". She visited after the funeral and he said, "They're coming to get me, they're going to kill me, they're going to cut me up." She contacted Mr Ash, who she said fobbed her off and said, "I'll see what I can do."

Mrs Fuji told us that Mr Everest was scared and agitated and he did not make any conversation, he was not Mr Everest. She said it was different to how he had been on cocaine but the look was the same.

He was ringing five to six times a day. On one occasion, Prison Officer Miss Forth, PCO, rang at night a few days after the burial, saying he keeps ringing his bell asking if Mum was alright and he was down.

Mr Everest was on mirtazapine in the morning and was like a zombie. He continued to say, "They're coming to get me, I'm not getting out of here." He said, "They are coming to get you and coming to get the kids." On the visit about 12th [February] he was sad, he discussed Mr Matterhorn, he was not eating, he talked about everyone "getting got".

He continued to phone. Mrs Fuji remembers him screaming down the phone, “They’re coming to cut me up”. Mrs Fuji rang the prison and said he should be in Healthcare. The officer said they would ring back but didn’t. The next day she rang and they said he had gone to Healthcare, she said he should have been there before now. They said that he had cut his arm but he’s on watch. Mrs Fuji’s friend phoned Mr Ash to check what was happening. He said he would get back to them but didn’t.

At 4 o'clock a liaison person asked her to go to A and E. She met Mr Ash there and he said he was sorry. Mrs Fuji said that she was very angry and shouting.

She said that the liaison officer would not tell her what had happened and told her to put it in writing to the Governor.

The doctor told her about the self-harm. When Mr Everest was in hospital, he was under 24-hour guard. Some of the officers were friendly and one said, “I knew he wasn’t well on wing.”

She said that they have never been told what happened. She said that she does not know how he got the burn mark on his arm. She said that the prison made no official contact after she told the liaison officer not to come – until she was asked to sign the release licence and they brought her a bag of clothes and personal effects.

Statements of Mrs Fuji

23/5/2016 and 23/12/ 2016

Mrs Fuji indicated that an acquaintance who works at Altcourse indicated that on the weekend of Mr Everest’s self-harm, the staff on duty were not adequately trained. His probation officer expressed concerns about the way he was treated.

Chapter 7 Critical Appraisal and Findings and Recommendations

What was the diagnosis?

Mr Everest had a history of physical abuse as a child and also witnessed significant domestic violence. He was frequently in trouble at school and was eventually excluded and received special education. He began offending in his teens, mainly acquisitive offending, and he misused cannabis and cocaine. He presented to his GP in the community, and also in previous prison sentences, with symptoms of depression and he had been on various antidepressants over the years, including latterly mirtazapine. In the 12 months prior to his most recent prison term he had also been referred to a Consultant Psychiatrist for management of his substance misuse, particularly his use of cocaine. Mrs Fuji describes that Mr Everest became highly suspicious and paranoid when he was taking cocaine, particularly in the six months prior to his reception into HMP Altcourse in December 2013. He was in a steady relationship, which was described as stormy, with multiple separations, and he had three children. He had a previous history of self-harm. He had previously been diagnosed with depression, substance misuse and borderline personality disorder.

In my opinion, reviewing the records and speaking to staff and Mrs Fuji, the most likely diagnosis is borderline personality disorder, characterised by a long history of impulsive behaviour in the form of self-harm, substance misuse, difficulties with emotional regulation and difficulties forming and sustaining consistent relationships. Mr Everest also fulfilled the criteria for a diagnosis of harmful use of substances and was possibly dependent on cocaine in the community. Periodically over the years he probably at times fulfilled diagnostic criteria for depression. In the period prior to his last prison term, he had some psychotic symptoms, in the context of cocaine misuse. He was seen by the Early Intervention Service but did not receive a diagnosis of schizophrenia. It was thought that these psychotic symptoms were related to his substance misuse.

Following reception into HMP Altcourse in December 2013, Mr Everest displayed symptoms of low mood and agitation. This was probably due to mild depression but also due to antidepressant withdrawal from mirtazapine. Mirtazapine has one of the lowest rates of withdrawal symptoms, from stopping the drug quickly,

compared with other antidepressants. Nevertheless, withdrawal is well described. Withdrawal symptoms include anxiety (in 70% of cases), dizziness (in 61%), dreams (in 51%), electric shocks (in 48%) and then non-specific symptoms such as stomach upsets, flu-like symptoms, headaches and insomnia. Rebound depression occurs in 7% of cases. Symptoms generally last up to six weeks but may be as long as 12 weeks. The Royal College of Psychiatrists recommends that stopping mirtazapine is done slowly, with gradual reduction, increasing the dose temporarily to control side effects if required. [In 'Coming off antidepressants'. See References] The National Institute for Health and Care Excellence [NICE] Mental Health Guidelines suggest, in cg90, a four-week period for withdrawal of antidepressants. The Maudsley Prescribing Guidelines in Psychiatry suggest that when one antidepressant is withdrawn and another introduced, there should be cautious cross-tapering over a four-week period. This involves reducing the dose of one drug and gradually introducing the next. [Chapter 4, page 296] In Mr Everest's case, the dose of mirtazapine was stopped abruptly on reception.

With the reinstatement of his mirtazapine, there was some indication that Mr Everest's agitation reduced. Unfortunately, his brother then died. Mr Everest appeared to be grieving and attended the funeral on 3rd February. Several staff and Mrs Fuji reported that he took the death of his brother very badly. Mrs Fuji reports that he then started to ring several times a day, in a distressed state. Mrs Fuji described that he was not himself and was describing strange experiences. On 21st February, staff reported that Mr Everest was incoherent and was describing the same strange experiences. He refused to engage with the ACCT process. On the morning of 22nd February, the day on which the incident of life-threatening self-harm later took place, he refused to go back into his cell and then refused to return from Healthcare. This was described as unusual behaviour for him. Mr Everest self-harmed twice over a 24-hour period and then attempted to hang himself.

In my opinion, it sounds like Mr Everest was displaying psychotic symptoms, probably from shortly after the funeral. He was described as paranoid by several staff members; he described visual hallucinations, for example seeing his daughter's head in his hands; he said his brother was in his cell; he described a fear that he may hear voices and he was described as walking in an unusual manner, with his arms outstretched as if carrying a weight. The cause of these

symptoms could be either a psychotic episode per se or a drug-induced psychosis.

Mr Everest had a previous history of cocaine-induced paranoia and suspiciousness and altered behaviour in the community. At interview, Mrs Fuji said that his appearance over the period after the funeral was not exactly like his cocaine-induced psychosis but that there were some similarities. Some staff considered that he might be under the influence of substances, but on balance they felt that he was not. Psychotic symptoms may occur in the context of a severe depression. From the description, it is not possible to tell whether he had severe depression; having considered all of the factors it would seem to be unlikely. The other possibility is that he developed a schizophrenia-like picture; but, again, without a clear description of his symptoms, it is not possible to say with certainty. In summary, in view of Mr Everest's previous drug-induced psychosis, and his previous propensity to misuse substances, the most likely cause of his apparent psychotic symptoms was substance misuse, possibly of cocaine or other stimulants. Staff at HMP Altcourse and the HMCIP report of an unannounced inspection in June 2014 indicated that around this time there was a rise in the use of drugs, particularly drugs such as NPS [new psychoactive substances]. These are often incorrectly called legal highs and they contain one or more chemical substances which produce similar effects to illegal drugs like cannabis, cocaine and ecstasy.

Care Pathway

Reception

Mr Everest was received into custody and had a reception health screen. He informed staff that he was on mirtazapine. He did not receive this drug. He was referred to the Substance Misuse team.

Mental health assessment

Mr Everest was seen by the prison GP who asked for his community GP records to be requested to check whether he was on mirtazapine. Mr Everest saw substance misuse staff and mental health staff and was described as agitated. Mrs Fuji stated that she was ringing the prison and after a few days went to the GP practice to see whether they had received a request for his records and they had not. Mr Everest was very distressed that he was not receiving his

medication. He was eventually seen by the GP who did not prescribe the mirtazapine but instead prescribed citalopram. It is not clear whether Mr Everest took this. He then continued to present in an agitated state to both healthcare and substance misuse staff. Eventually, he was prescribed the mirtazapine but at a reduced dose and in the morning instead of the evening. His agitation settled.

Mental health care

Mr Everest received intensive nursing input after he was admitted and was experiencing agitation about his medication and again after the death of his brother. This input was supportive to Mr Everest. I was, however, concerned that there was no detailed mental health assessment. Indeed, at no point was a full history taken, including a history of symptoms and mental health problems. It would have been useful to have a full diagnostic assessment in order to plan a strategy of care, thus avoiding the reactive kind of care that was in fact provided.

Days leading up to the incident

In the last few days prior to the incident, there was concern about a deterioration in Mr Everest's mental health, including the possible development of psychotic symptoms. He should have received a full psychiatric assessment at that point to establish whether he was psychotic and what the likely cause was. The change in his presentation was not explored, nor the cause. There was mention of a urine drug screen but there was no evidence that he had this. I could find no results for drug testing in the case notes.

The following six sets of Findings and Recommendations, namely 1 – 6, relate to the Care Pathway.

Findings and Recommendation 1

Finding relating to Recommendation 1

Mr Everest did not receive his prescribed antidepressant on reception into prison.

Recommendation 1

This recommendation is for HMP Altcourse healthcare staff but also applies to healthcare provision in HM Prison and Probation Service's estate nationally.

There needs to be much speedier medicines reconciliation, post reception. In prisoners, like Mr Everest, who are prescribed drugs like antidepressants, this needs to be within 24 hours to avoid withdrawal symptoms. There needs to be a robust administration process whereby a summary is acquired from the GP in the community, outlining the person's medication. If someone is definitely prescribed a medication in the community, they should be prescribed it immediately and then they should be reviewed by Healthcare staff to assess whether the medication is appropriate. If there is uncertainty about the medication from the GP summary sheet, received from the community, the practice should be contacted to gather this information.

Findings and Recommendation 2

Findings relating to Recommendation 2

Dr Tulip indicated that there are concerns about prescribing mirtazapine in custody because of its sedative effect and therefore it potentially has some currency in a prison as a drug of misuse. He said that the RCGP [Royal College of General Practitioners] guidelines for prison prescribing, 'Safer prescribing in Prisons. Guidance for Clinicians', indicate that mirtazapine should be prescribed with caution. The Guideline states that

> *"Although mirtazapine use may be appropriate within a secure environment, any prescribing decision should take into account the medication's links with substance misuse where it may be taken simply as a form of night sedation." "It has definite potential for diversion and patients in receipt of mirtazapine may be subject to bullying. All these potential pitfalls should be considered in any prescribing decision. When prescribing is considered appropriate it should prescribed in an orodispersible form only. Urine drug testing should be considered to*

ensure compliance and the absence of illicit opiates. It should only be prescribed second or third line in major depression. Morning administration may reduce its popularity."

['Safer prescribing in Prisons. Guidance for Clinicians', November 2011. Page 19, section 5]

However, it is destabilising to stop medication on reception into custody. This is because reception into custody is a stressful time, and stopping medication suddenly, particularly drugs like mirtazapine, can cause drug withdrawal but also relapse of illness.

On balance, Mr Everest's medication should have been prescribed when the validity of the prescription was confirmed by his community GP and then he should have been reviewed and alternative treatment discussed if appropriate. The agitation was likely to be due, in part, to antidepressant withdrawal.

Recommendation 2

This recommendation is for HMP Altcourse healthcare staff but also applies to healthcare provision in HM Prison and Probation Service's estate nationally.

If a prisoner comes into prison on mirtazapine, he/she should have a full review, following confirmation of that prescription from the community GP. This should happen quickly. If an alternative to mirtazapine prescription is considered appropriate, the person should be reduced slowly from mirtazapine and the new drug introduced gradually, as per the Maudsley Prescribing Guidelines. If mirtazapine prescription needs to continue, the RCGP guidelines should be followed with prescription of the orodispersable form and with urine drug-testing for compliance and the absence of illicit drugs. Morning administration should be considered and the effects of this reviewed with the prisoner.

Findings and Recommendation 3

Findings relating to Recommendation 3

Mr Everest did not have a full mental health history taken at any point during his final prison term. There was no summary of his community and previous prison records, no diagnosis and no formulation of his psychological needs, treatment needs and risk of self-harm and harm to others. [A formulation is a systematic and precise statement of a problem, with exploration and explanation of components of the problem.] The absence of this approach often leads to reactive care, with staff basing their decisions on current mental state examination, without putting current symptoms into a historical context.

Recommendation 3

The following recommendations are for Healthcare staff at HMP Altcourse but also apply to healthcare provision in HM Prison and Probation Service's estate nationally.

I recommend that all prisoners should have a mental health assessment within 72 hours of entering custody, for case-finding (i.e. detection of people with likely mental health problems). Prison Service Instruction (PSI) 74/2011 Early Days in Custody – Reception In, First Night in Custody, and Induction to Custody indicates that all prisoners should have a health review within a week of reception but this does not specify a full mental health assessment. People with a likely mental health problem should then be triaged to receive care appropriate to their needs. Records from the GP and secondary care mental health should be requested and summarised. The mental health practitioner should use a psychological formulation to understand the person's needs and risks in order to plan care accordingly.

The above recommendations for a full history, mental state and psychological formulation would be the gold standard. From my experience in prisons, the assessment Mr Everest received would not be unusual and the somewhat cross-sectional approach to his care would also not be uncommon. Therefore the care

provided by Altcourse in terms of assessment, diagnosis and care-planning was not significantly different to care provided in prisons as a whole, but this falls short of the kind of analytical approach required in complex cases such as these.

Findings and Recommendations 4 – 6

Findings relating to Recommendations 4 – 6

Mr Everest's mental state changed in the period leading up to his attempted hanging. He became incoherent and several staff noticed this. An ACCT was opened. The ACCT assessor was very concerned about his presentation. Mr Everest subsequently self-harmed on two separate occasions. He was moved to Healthcare. He did not have a mental health assessment on admission to Healthcare, to establish diagnosis, needs and risk. Also, at interview, one of the members of non-healthcare staff working in Healthcare indicated that she knew nothing about his history but that this was not uncommon.

Recommendations 4 to 6 are for healthcare staff at HMP Altcourse but also apply to healthcare provision in HM Prison and Probation Service's estate nationally.

Recommendation 4

A prisoner presenting with an altered mental state, particularly with possible psychotic symptoms, should be assessed at the earliest opportunity by a suitably-qualified mental health practitioner. The practitioner should take a full history, review previous entries and assess the person's current mental state to establish the diagnosis. The prisoner should be referred to a psychiatrist as soon as possible if psychosis is suspected.

Recommendation 5

A prisoner admitted as an in-patient to Healthcare should have a full assessment, with review of the case notes and a current mental state examination. Their needs and risks of self-harm and harm to others should be established and

suitable care plans developed. This assessment should inform the ACCT process, including the provision of observations, frequency of reviews et cetera.

Recommendation 6

There should be proportionate information sharing between healthcare and non-healthcare staff so that all staff are aware of the person's needs, risks, risk factors and likely triggers. Some of this information exchange will be via the ACCT process but there should also be robust handovers at times when staff change shifts, including appropriate sharing of risk-pertinent information with non-healthcare staff, particularly in in-patient services.

Assessment of risk of self-harm

Findings and Recommendation 7

Findings relating to Recommendation 7

Mr Everest was seen on a very regular basis between his reception on 6th December 2013 and the life-threatening self-harm on 22nd February 2014. Mental health and substance misuse staff reported that they assessed Mr Everest's risk of self-harm every time they saw him. In order to assess risk properly, it is essential to take a full history, to establish the likely risk and protective factors. Staff had established some of these; for example, there is reference in the records to his family being protective. However, there was no evidence of exploration of risk factors surrounding the previous self-harm, nor about suicidal ideas, intent, planning et cetera. Without this detailed assessment, it is not possible to fully assess risk as the practitioner just relies on what the person is saying in the 'here and now'.

In view of concerns about Mr Everest's changing presentation on 21st February 2014, he was seen by the ACCT assessor. He would not engage with the process and the ACCT assessor was very concerned about him. The first review involved a member of healthcare staff, but his change in presentation, his self-harm and his non-engagement with the ACCT process should have precipitated a full mental health assessment and this did not occur.

Recommendation 7

This recommendation is for all HMP Altcourse staff and for HM Prison and Probation Service nationally.

As part of the mental health assessment post-reception, all prisoners should have an assessment of their risk to self and others. If they are thought to be a self-harm risk, either at this assessment or at a later stage in the prison term, then a full risk assessment should be conducted, including establishing likely risk and protective factors.

The ACCT process

Findings and Recommendations 8 – 10

Findings relating to Recommendations 8 – 10

The staff at all levels within HMP Altcourse were compliant with Prison Service Instruction (PSI) 64/2011 Management of Prisoners at Risk of Harm to Self, to Others and from Others, which covers ACCT, suicide and self-harm procedures.

All staff were trained regularly in ACCT. The level of contact with Mr Everest through the ACCT process was very good, and the quality of recording each conversation from different staff throughout is an example of good practice. Staff indicated that healthcare staff are encouraged to attend all ACCT reviews. This is commendable. However, the ACCT assessor does not routinely attend the first review, which again is a missed opportunity as the person doing this assessment would provide useful information to the review.

There was no contact with Mr Everest's family during the ACCT process, although admittedly he had only been on an ACCT for a matter of hours, when his life-threatening self-harm took place. Throughout the prison system, there is little involvement of the family in the ACCT process. This is a missed opportunity as family would be a great potential source of information on risk and could assist in the care-planning and monitoring functions.

Recommendations 8 – 10

These recommendations are for all staff at HMP Altcourse but are also relevant for all staff in HM Prison and Probation Service nationally.

Recommendation 8

The ACCT assessor, where possible should attend the first review to pass on details of their findings and impressions to other staff.

Recommendation 9

Where possible, there should be consistency of attendance at ACCT reviews.

Recommendation 10

Where possible, families should be encouraged to input into the ACCT process.

Peer supporters

Findings and Recommendation 11

Findings related to Recommendation 11

There is no evidence from the records or from the interviews that consideration was given to placing Mr Everest with a peer supporter. In many prisons, peer support is provided by Listeners. These are prisoners trained by the Samaritans. HMP Altcourse provides peer support through carers who perform a similar role to Listeners but who are not trained by Samaritans. These peer supporters have knowledge about mental health and self-harm and provide confidential support for fellow prisoners. Whilst the role of the peer supporter has never been formally evaluated, there are several studies highlighting the potential value of this peer input. This could have been particularly useful with Mr Everest, given his level of agitation, as it might have provided more consistent reassurance to him.

Recommendation 11

This recommendation is for HMP Altcourse staff.

There needs to be consideration of the value of input from peer supporters in all cases when someone is on an ACCT or vulnerable to self-harm and this should be documented in the ACCT document and healthcare records.

Observations

Findings and Recommendations 12

Findings related to Recommendation 12

Mr Everest's prescribed level of observation was five times every hour and irregular [he needed to be observed five times an hour but the observations were not to be evenly-spaced or predictable]. He was not placed in a safer cell; there was no information in the healthcare notes or in the ACCT On-going record or ACCT review indicating whether or not this had been considered. A safer cell is a cell where attention has been paid to potential ligature points. Prisons usually have a small number of these. There was a recommendation that he remain on 5/hour [five times every hour] observations but there was no information in the notes to show whether consideration was given for constant observations. [This is where the person is observed by a member of staff constantly.] All interviewed staff stated that a constant watch could be used at any time; there were no apparent concerns about cost or resource implications of this but it was used rarely. Staff seemed unsure what the criteria for use of constant observations should be.

Recommendation 12

This recommendation is for all HMP Altcourse staff but is also of relevance for HM Prison and Probation Service nationally.

There needs to be a clear policy on levels of observations to be used and the criteria for placement in a safer cell or under constant observation and these should be fully documented in an individual's ACCT document and healthcare records.

Emergency medical response

Findings and Recommendations

The process of resuscitation was, from all accounts, managed well, with no delays in providing immediate life support, calling the ambulance or documentation in the case record.

There are no recommendations.

Communication and consultation with relatives

Findings and Recommendations 13

Findings relating to Recommendations 13 – 15

Mrs Fuji was extremely concerned about her son's deteriorating mental health and rang the prison on multiple occasions. There is no evidence of documentation of these calls in any records, nor any indication that Mrs Fuji's concerns were acted upon. A prisoner's relative, carer or friend is usually in a good position to discern whether a person's mental state is deteriorating. They know them the best and can therefore easily determine change. Mrs Fuji described being put through to various departments and she spoke to several different people. She described that her concerns were not acted upon and she described being 'fobbed off''. She was also not consulted with at any point about Mr Everest's history, previous treatment or risk. As mentioned above, she was not included in the ACCT process.

Recommendations 13 – 15

These recommendations are for all HMP Altcourse staff but are also relevant for HM Prison and Probation Service nationally.

Recommendation 13

There should be a clear procedure for relatives, carers and friends to contact the prison to pass on information, express concerns or inquire about their loved-one's wellbeing. Some prisons have a telephone hotline service, with a guarantee that the appropriate department will respond. Not only should there be a point of access for a relative, but there needs to be a mechanism whereby the information they provide gets to the appropriate departments.

Recommendation 14

With the prisoner's consent, a prisoner's relatives should be contacted to gather information as a collateral history is extremely useful. They should also be given information, again with consent, about the prisoner's condition. They should be included in care-planning meetings and the ACCT process where appropriate.

Recommendation 15

This is the gold standard approach to family involvement. Prisons vary in the quality of family involvement and HMP Altcourse is sadly not unusual in how it approaches this important area. There should be improved across all prisons.

Information and Documentation

Findings and Recommendations 16

Findings relating to Recommendation 16

Mr Everest was seen regularly by a number of different professionals. The nursing staff documented their entries in the healthcare records and the ACCT folder, as did ACCT personnel including the officers. The Chaplain saw him

regularly but the Chaplaincy has no regular log of interactions with prisoners and most of the Chaplain's encounters with Mr Everest were undocumented. Chaplains may discuss complex issues with prisoners, yet this is not documented. Furthermore, the Chaplain indicated that there was no regular forum to meet with Healthcare to discuss mutual cases. The same applied to other professionals; the GP indicated that it would be useful to discuss complex cases with the Mental Health team.

The Substance Misuse team write in the medical record [SystmOne] but also keep separate, more detailed notes. The counsellor at the prison kept his own records. These staff indicated that they would also welcome reviews jointly with Mental Health.

The problem with multiple records and not documenting findings is that various people know little snippets of information and no-one has a complete picture of symptoms, concerns and therefore risk. From a systems point of view, it should be considered how encounters with, for example the Chaplain, are documented and in which case notes. It is a balance between confidentiality and other staff needing to know certain information.

Recommendation 16

This recommendation is for all staff at HMP Altcourse but also has relevance for HM Prison and Probation Service nationally.

Everyone seeing a prisoner should write in a record, either in SystmOne or the prison record. The counsellor and substance misuse worker should write in SystmOne and the Chaplain in the prison record (P-NOMIS). It is good practice to have regular case conferences for complex cases, with documentation of an action plan to be placed in all records.

Internal assessment, the aftermath and de-brief

Findings and Recommendations 17 – 20

Findings related to Recommendations 17 – 20

The initial internal investigation commissioned immediately after the self-harm incident on the 22nd February 2014 was poor. It was lacking in both content and detail.

A full investigation, carried out by a senior manager, should be commissioned immediately after any serious self-harm incident. It must consider all relevant facts including staff involved, history of the prisoner, location of the incident, and pertinent information about the prisoner's behaviour prior to the self-harm. This should be the start of the lessons-learned process to help to prevent future instances of self-harm.

The relationship between the Family Liaison Officer and the family was poor. The Family Liaison Officer needs to build a supportive relationship with the family, keeping them informed of all developments.

The staff involved in the incident did not have a formal debrief. They were also not offered counselling or support as a matter of course, although many of them told us at interview that they could get this if required.

The prison maintained contact with Mr Everest's treating team following his transfer to hospital. They kept prison officers with him for a few weeks and then withdrew, just having contact at set intervals to gauge his progress. This was managed well.

Recommendations 17 – 20

These recommendations are for HMP Altcourse.

Recommendation 17

The prison should develop a robust method for investigating serious untoward incidents using root cause analysis methodology.

Recommendation 18

The prison needs to ensure that the Family Liaison Officer role is performed by someone with the correct experience and skills.

Recommendation 19

The prison should perform a formal debrief for all staff involved in a serious incident, with the offer of counselling support.

Recommendation 20

The prison must ensure that when a prisoner is on a bed watch in hospital and in a poor state of health, following an incident of life threatening self-harm, they achieve a balanced risk assessment of the need to have prison officers present to protect the public and the prisoner's dignity and privacy. The family's views should be taken into account regarding this.

Injury

When I visited Mr Everest on 5th May 2016 I noted that he has a scar on his right arm. There is reference in the records to an incident of self-harm by cutting on 22/02/2014. In the F213 SH document dated 22/02/2014 10.30 a.m. the related diagram shows four horizontal cuts. It is possible that the scarring was caused by this but, from my memory of the scar, it is linear and vertical. There is no other reference in the records to any other injuries to the right arm. I am not an expert in scarring and therefore I am unable to conclude whether the episode of self-harm was the cause of this scar.

Public Scrutiny

In my opinion, there was no conflicting evidence between the records and interviews and no evidence of gross systemic failure. In my view a public hearing is not required.

Recommendations

Recommendations 1 – 6 relate to the Care Pathway.

Recommendation 1

This recommendation is for HMP Altcourse healthcare staff but also applies to healthcare provision in HM Prison and Probation Service's estate nationally.

There needs to be much speedier medicines reconciliation, post reception. In prisoners, like Mr Everest, who are prescribed drugs like antidepressants, this needs to be within 24 hours to avoid withdrawal symptoms. There needs to be a robust administration process whereby a summary is acquired from the GP in the community, outlining the person's medication. If someone is definitely prescribed a medication in the community, they should be prescribed it immediately and then they should be reviewed by Healthcare staff to assess whether the medication is appropriate. If there is uncertainty about the medication from the summary sheet, the practice should be contacted to gather this information.

Recommendation 2

This recommendation is for HMP Altcourse healthcare staff but also applies to healthcare provision in HM Prison and Probation Service's estate nationally.

If a prisoner comes into prison on mirtazapine, he/she should have a full review, following confirmation of that prescription from the community GP. This should happen quickly. If an alternative to mirtazapine prescription is appropriate, the person should be reduced slowly from mirtazapine and the new drug introduced gradually, as per the Maudsley Prescribing Guidelines. If mirtazapine prescription needs to continue, the RCGP guidelines should be followed with prescription of the orodispersable form and with urine drug-testing for compliance and the absence of illicit drugs. Morning administration should be considered and the effects of this reviewed with the prisoner.

Recommendation 3

The following recommendations are for Healthcare staff at HMP Altcourse but also apply to healthcare provision in HM Prison and Probation Service's estate nationally.

I recommend that all prisoners should have a mental health assessment within 72 hours of entering custody, for case-finding. Prison Service Instruction (PSI) 74/2011 Early Days in Custody – Reception In, First Night in Custody, and Induction to Custody indicates that all prisoners should have a health review within a week of reception but this does not specify a full mental health assessment. People with a likely mental health problem should then be triaged to receive care appropriate to their needs. Records from the GP and secondary care mental health should be requested and summarised. The mental health practitioner should use a psychological formulation to understand the person's needs and risks and plan care accordingly.

The above recommendations for a full history, mental state and psychological formulation would be the gold standard. From my experience in prisons, the assessment Mr Everest received would not be unusual and the somewhat cross-sectional approach to his care would also not be uncommon. Therefore the care provided by Altcourse in terms of assessment, diagnosis and care-planning was not significantly different to care provided in prisons as a whole, but this falls short of the kind of analytical approach required in complex cases such as these.

Recommendations 4 – 6

These recommendations are for healthcare staff at HMP Altcourse but also apply to healthcare provision in HM Prison and Probation Service's estate nationally.

Recommendation 4

A prisoner presenting with an altered mental state, particularly with possible psychotic symptoms, should be assessed at the earliest opportunity by a suitably-qualified mental health practitioner. The practitioner should take a full history, review previous entries and assess the person's current mental state to

establish the diagnosis. The prisoner should be referred to a psychiatrist as soon as possible if psychosis is suspected.

Recommendation 5

A prisoner admitted as an in-patient to Healthcare should have a full assessment, with review of the case notes and a current mental state examination. Their needs and risks of self-harm and harm to others should be established and suitable care plans developed. This assessment should inform the ACCT process, including the provision of observations, frequency of reviews et cetera.

Recommendation 6

There should be proportionate information sharing between healthcare and non-healthcare staff so that all staff are aware of the person's needs, risks, risk factors and likely triggers. Some of this information exchange will be via the ACCT process but there should also be robust handovers at times when staff change shifts, including appropriate sharing of risk-pertinent information with non-healthcare staff, particularly in in-patient services.

Recommendation 7 relates to assessment of risk of self-harm.

Recommendation 7

This recommendation is for all HMP Altcourse staff and for HM Prison and Probation Service nationally.

As part of the mental health assessment post-reception, all prisoners should have an assessment of their risk to self and others. If they are thought to be a self-harm risk, either at this assessment or at a later stage in the prison term, then a full risk assessment should be conducted, including establishing likely risk and protective factors.

Recommendations 8 – 10 relate to the ACCT process.

Recommendations 8 – 10

These recommendations are for all staff at HMP Altcourse but are also relevant for all staff across in HM Prison and Probation Service nationally.

Recommendation 8

The ACCT assessor, where possible should attend the first review to pass on details of their findings and impressions to other staff.

Recommendation 9

Where possible, there should be consistency of attendance at ACCT reviews.

Recommendation 10

Where possible, families should be encouraged to input into the ACCT process.

Recommendation 11

This recommendation is for HMP Altcourse staff.

There needs to be consideration of the value of input from peer supporters in all cases when someone is on an ACCT or vulnerable to self-harm and this should be documented in the ACCT document and healthcare records.

Recommendation 12 relates to observations.

Recommendation 12

This recommendation is for all HMP Altcourse staff but is also of relevance for HM Prison and Probation Service nationally.

There needs to be a clear policy on levels of observations to be used and the criteria for placement in a safer cell or under constant observation and these should be fully documented in an individual's ACCT document and healthcare records.

Recommendations 13 – 15 relate to communication and consultation with relatives.

Recommendations 13 – 15

These recommendations are for all HMP Altcourse staff but are also relevant for HM Prison and Probation Service nationally.

Recommendation 13

There should be a clear procedure for relatives, carers and friends to contact the prison to pass on information, express concerns or inquire about their loved-one's wellbeing. Some prisons have a telephone hotline service, with a guarantee that the appropriate department will respond. Not only should there be a point of access for a relative, but there needs to be a mechanism whereby the information they provide gets to the appropriate departments.

Recommendation 14

With the prisoner's consent, a prisoner's relatives should be contacted to gather information as a collateral history is extremely useful. They should also be given information, again with consent, about the prisoner's condition. They should be included in care-planning meetings and the ACCT process where appropriate.

Recommendation 15

This is the gold standard approach to family involvement. Prisons vary in the quality of family involvement and HMP Altcourse is sadly not unusual in how it approaches this important area. There should be improved across all prisons.

Recommendation 16 relates to information and documentation.

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