Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Graham Taylor, a prisoner at HMP Dartmoor, on 17 December 2021

## A report by the Prisons and Probation Ombudsman

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## OUR VISION

**To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.**

## WHAT WE DO


## WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Graham Taylor died after he was found hanged in his cell on 17 December 2021 at HMP Dartmoor. Mr Taylor was 64 years old. I offer my condolences to his family and friends. Mr Taylor was the fourth prisoner to take his own life at Dartmoor in three years.

The clinical reviewer concluded that the clinical care provided to Mr Taylor at Dartmoor was equivalent to that which he could have expected to receive in the community. She makes recommendations for HMP Exeter, Mr Taylor's previous prison, regarding management of his pain relief.

We found that the non-clinical care provided to Mr Taylor at Dartmoor was good overall. However, we are concerned about the delays in providing pain relief medication at Exeter and the impact this had on Mr Taylor's mental health. The process must be reviewed to improve future care.

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

**Adrian Usher**
**Prisons and Probation Ombudsman** **December 2023**

# Contents

# Summary

## Events

1. Mr Graham Taylor was convicted of sex offences on 2 August 2021. On 12 November, he was sentenced to six years imprisonment and sent to HMP Exeter.

2. Mr Taylor was distressed when he arrived at Exeter. He told staff on reception that he wanted to take his own life by going on a hunger strike. Staff began monitoring him under suicide and self-harm prevention procedures (known as ACCT).

3. Mr Taylor was prescribed with pain relief medication for a historic back injury. The medication was not reconciled for four weeks while the healthcare team assessed its appropriateness. The delay had a significant impact on Mr Taylor's wellbeing. He said he would take his own life if he did not receive his prescription.

4. On 13 December, Mr Taylor was transferred to HMP Dartmoor while subject to ACCT monitoring. The next day, at his first ACCT review meeting at Dartmoor, staff decided to close the ACCT because they were satisfied his risks had reduced. They put post-closure monitoring in place to review the decision.

5. At 5.14am on 17 December, during the morning routine check, an officer opened Mr Taylor's cell observation panel and found him ligatured from a bar on the window with a piece of towel. She immediately radioed a medical emergency code, indicating a life-threatening situation and requesting an ambulance.

6. Staff responded quickly to the code blue; however, they did not attempt cardio-pulmonary resuscitation (CPR) as it was clear that Mr Taylor had been dead for some time. Paramedics confirmed that Mr Taylor had died at 5.45am.

## Findings

## Clinical care

7. The clinical reviewer concluded that the clinical care Mr Taylor received at Dartmoor was of a reasonable standard and equivalent to that which he could have expected to receive in the wider community.

## Management of risk

8. Staff at Exeter rightly monitored Mr Taylor under ACCT when he shared suicidal thoughts about his chronic pain. The healthcare team was assessing his pain relief prescription, during which time a weaker form of relief was issued. Mr Taylor continued to report pain and the significant impact it was having on his mental health, but the medication assessment was not expedited. It took four weeks to reconcile the prescription which was an unacceptable delay in the circumstances.

9. Mr Taylor's ACCT was transferred with him to Dartmoor. Staff reviewed the risks one day after his arrival and decided to close the ACCT. Mr Taylor's medication had been organised and he was feeling safer and more positive at Dartmoor. Staff put

Mr Taylor's ACCT in 'post-closure' with regular reviews of the decision to close, which did not find any concerns. Although the decision to close the ACCT was quick and staff had a limited period of time to get to know Mr Taylor, we consider the decision was proportionate in the circumstances. Staff had no reason to consider there was an imminent risk of harm and had the opportunity to regularly review Mr Taylor's safety through the post-closure process.

## Recommendations

- **The GP Lead at HMP Exeter should review prescribing processes to ensure high-risk medication assessments are completed in a timely way, with consideration of the impact on the individual**

# The Investigation Process

11. We were notified of the death of Mr Taylor on 17 December 2021. The investigator issued notices to staff and prisoners at HMP Dartmoor informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

12. The investigator obtained copies of relevant extracts from Mr Taylor's prison and medical records.

13. The investigator interviewed six members of staff at Dartmoor. The interviews were completed by video link due to the restrictions imposed as a result of the COVID-19 pandemic.

14. NHS England commissioned a clinical reviewer to review Mr Taylor's clinical care at the prison. The interviews were conducted jointly by the clinical reviewer and the investigator.

15. We informed HM Coroner for Exeter and Greater Devon of the investigation and have sent the coroner a copy of this report.

16. The Ombudsman's family liaison officer contacted Mr Taylor's son to explain the investigation and to ask if he had any matters that he wanted the investigation to consider. He did not ask any specific questions but shared some additional information on Mr Taylor's circumstances with us, which are referenced in this report. He also requested a copy of this report.

17. We shared the initial report with HM Prison and Probation Service. They did not identify any factual inaccuracies.

18. We also shared the initial report with Mr Taylor's son. He did not provide any comments.

# Background Information

## HMP Dartmoor

19. HMP Dartmoor is a Category C prison, which holds up to 640 adult male prisoners. Healthcare services are provided by Care UK and mental healthcare is provided by Devon Partnership NHS Foundation Trust.

## HM Inspectorate of Prisons

20. The last full inspection at HMP Dartmoor was in August 2017. HMIP completed a short scrutiny visit in September 2020 (scrutiny visits focused on how establishments were recovering from the challenges of the COVID-19 pandemic). Inspectors reported that the quality of ACCT documents was poor, with entries that lacked detail, incomplete initial action and care plans and no quality assurance process to address these issues. Inspectors were also concerned that key work (a scheme where assigned prison officers meet with prisoners for an average of 45 minutes a week, in an effort to build meaningful relationships with them) had not got back on track after being halted at the start of COVID-19 related regime restrictions. Inspectors recommended that key worker sessions should be resumed for all prisoners, with a focus on wellbeing and rehabilitation.

## Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 30 September 2022, the IMB reported that the number of self-harm incidents was lower than the previous year, and that Listeners continued to play a vital role in supporting vulnerable men.

22. They reported that ACCT reviews were being conducted professionally, with a focus on the needs of the individual. Detailed records were presented at the review meetings and there was clear evidence of a multidisciplinary approach.

23. In its previous annual report, for the year to 30 September 2021, the IMB reported that COVID-19 restrictions meant prisoners were locked-up for extensive periods, had no face-to-face visits for much of the year and had their activities restricted. All these measures were affecting prisoners' wellbeing.

## Previous deaths at HMP Dartmoor

24. Mr Taylor was the twelfth prisoner to die at Dartmoor since December 2018. Of the previous deaths, eight were from natural causes and three were self-inflicted. We found no similarities between these deaths and the death of Mr Taylor.

25. Since Mr Taylor's death, one further prisoner took his own life at Dartmoor in October 2022. We found no similarities between this death and the death of Mr Taylor.

## Assessment, Care in Custody and Teamwork

26. Assessment, Care in Custody and Teamwork (ACCT) is the HMPPS care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

27. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

28. Following the closure of an ACCT, the 7-Day Post-Closure Monitoring Form must be completed for a minimum of 7 days in order to inform the post-closure review. The form will need to be completed up until the day the post-closure review takes place.

29. As soon as practically possible following this 7-day monitoring period, the ACCT Case Coordinator must chair a post-closure review, reviewing the Support Actions and the progress made since the ACCT was closed. During the post-closure review, consideration should be given to the current feelings of the prisoner, access to support (both formal and informal), and progress since closure.

30. At the end of the review, the Case Coordinator and any other members of the case review team present will decide whether there needs to be any further post-closure reviews (and, if so, their frequency), or whether the ACCT needs to be re-opened. The review (including the outcome and discussion) must be documented on the Post-Closure Review Form.

# Key Events

## HMP Exeter

31. On 2 August 2021, Mr Graham Taylor was convicted of sex offences and released on bail awaiting sentencing. On 12 November, he was sentenced to six years imprisonment and sent to HMP Exeter. It was his first time in prison. Mr Taylor told his barrister that he was thinking about taking his own life because he was innocent.

32. At the initial healthcare screening, Mr Taylor said he was in 'constant pain' due to shoulder and back injuries. He was prescribed tramadol (pain relief) in the community.

33. Mr Taylor was distressed when he arrived at Exeter. He told staff on reception that he was struggling to come to terms with being in prison for something he did not do and was concerned about the length of his sentence. He said he wanted to take his own life by going on hunger strike. Staff began monitoring Mr Taylor using suicide and self-harm prevention procedures known ACCT. Initially, Mr Taylor was placed on hourly ACCT observations.

34. The next day, at Mr Taylor's initial ACCT assessment, he told staff that he wanted to die of a heart attack. He said he could stop taking his diabetes medication in order to cause his death. He also said it would be easy to electrocute himself in his cell, but that he did not "have the guts" to do it. Later on, at Mr Taylor's first ACCT review, he presented more positively. Although he talked a lot about how his conviction was a "stitch up" and that he was innocent of all charges, he said he would like to transfer to a prison where he could spend more time outside. He also said he wanted to speak to his son and a friend, once the appropriate checks had been completed. Following the review, staff agreed that the ACCT should remain open but changed the level of observations from hourly to two conversations per day and hourly observations at night.

35. On 15 November, staff at Exeter received Mr Taylor's medical records. The records confirmed he had been prescribed tramadol for some time, to treat chronic pain in his shoulder and back. Healthcare staff did not automatically issue a prescription due to concerns regarding opioid based medication in a prison setting (namely the high risk of misuse, diversion and the potential psychoactive effects). They prescribed paracetamol and ibuprofen as an alternative pain relief medication while assessing the appropriateness of tramadol.

36. On 18 November, Mr Taylor tested positive for COVID-19 and was required to self-isolate for a period of 14 days. Staff completed daily wellbeing checks and reported no serious concerns.

37. On 19 November, the next ACCT case review took place. Mr Taylor told staff that he had no thoughts of suicide or self-harm but said he was suffering with physical pain which was affecting his sleep. He was starting to adjust to prison life day by day. Following the review, staff reduced the number of nightly observations to four based on Mr Taylor's improved presentation and behaviour. No one from the mental health team attended the review.

38. On 25 November, a further ACCT case review took place. Mr Taylor told staff that he had no thoughts of suicide or self-harm but was still struggling with physical pain and wanted his tramadol reinstated. Staff decided that Mr Taylor's risks had reduced so placed his ACCT under review in a "post-closure" state, meaning it could be reopened if additional concerns arose.

39. On 27 November, Mr Taylor's twin brother died. This was a very difficult time for Mr Taylor, and his anxiety increased. In interview, the prison chaplain who spent time with Mr Taylor at both Exeter and Dartmoor, told us that she found it difficult to obtain information about the death and said that Mr Taylor's family did not want him to attend the funeral.

40. On 29 November, a mental health nurse from the primary care mental health team assessed Mr Taylor through his cell door. Mr Taylor said he was not doing well following his twin brother's death. He told her that he was in so much physical pain it was causing him to have suicidal thoughts. She requested that the GP see Mr Taylor to discuss his pain medication. She also diarised a full triage for 1 December, when Mr Taylor was due to finish his COVID-19 isolation. Mr Taylor recovered well from COVID but said he found the isolation period difficult.

41. On 1 December, the mental health nurse attended Mr Taylor's cell to complete the planned triage. She was unable to complete the assessment properly because Mr Taylor's cell mate had to isolate for a further four days. She told Mr Taylor that he would not be able to attend a GP appointment until his isolation period had ended. Mr Taylor reiterated to her that the pain was causing him to have suicidal thoughts and told her he could not continue to live like this. It is clear from Mr Taylor's records that his ACCT was reopened on 1 December, but this is not clear from the ACCT document itself. It is also not clear when the ACCT closure was reviewed and who attended the review. Staff decided that two conversations a day and hourly observations at night was appropriate.

42. On 3 December, the next ACCT review took place. Mr Taylor told staff he had taken tramadol for 18 years in the community and was struggling with constant pain. He added that he was struggling emotionally following his twin brother's death. A mental health nurse attended the review and booked Mr Taylor in for a further mental health assessment once his isolation period was over.

43. On 5 December, a mental health nurse completed a full mental health triage assessment of Mr Taylor (23 days after he arrived at Exeter). Mr Taylor declined antidepressants and said that stopping his physical pain was the only thing that would improve his mood. He rated his mood as one out of ten and told the nurse, "if anything happened to me it would be because of the pain and not being on correct medication". Mr Taylor cited his partner and son as protective factors, with whom he had regular contact. The nurse told Mr Taylor that she had asked the GP to review his medication but said the appointment had been delayed due to him and his cellmate being in isolation. She also recommended that the chaplaincy support Mr Taylor going forward.

44. On 6 December, Mr Taylor's case was discussed at the multi-disciplinary team (MDT) meeting. On 8 December, the next ACCT review took place. Both operational prison staff and a mental health nurse attended it. Mr Taylor repeatedly told staff that he had no thoughts or plans of suicide or self-harm but that the pain

was causing him to have suicidal thoughts. Staff told him that a GP appointment had been booked in to discuss pain relief.

45. On 9 December, the mental health team completed a comprehensive risk assessment and care plan which detailed Mr Taylor's recent life stressors including the death of his brother, chronic pain and recent COVID-19 isolation.

46. On 10 December, a GP completed a telephone consultation with Mr Taylor to discuss pain relief. Mr Taylor told the GP that historically, he suffered a serious shoulder injury, underwent triple heart bypass surgery and had his toe amputated (related to his diabetes) which subsequently became infected. He also had a fall from a cattle lorry and hurt his back in 2020, and broke his ribs and coccyx. The GP prescribed tramadol to help manage the pain.

## HMP Dartmoor

47. On 13 December, Mr Taylor was transferred to HMP Dartmoor for longer term prisoners and their associated needs. His ACCT was transferred too.

48. The reception nurse referred Mr Taylor to the mental health team on the basis of his open ACCT. He recorded on Mr Taylor's medical record that he was "now happy as on medication" and that had no current thoughts of suicide or self-harm. He described Mr Taylor's mood as "normal" and raised no concerns.

49. At around 3.30pm, a Supervising Officer (SO) completed an interim review of Mr Taylor as part of the induction process. She recorded that Mr Taylor was in a good mood. He said the ACCT had been opened at Exeter due to the pain he was experiencing. Mr Taylor said he was now in a much better place because he had his medication and was no longer in pain.

50. An officer completed Mr Taylor's induction and cell sharing risk assessment (CSRA). Mr Taylor told him that he was happy to be at Dartmoor and would be able to settle there. Mr Taylor also said that he hoped his ACCT would be closed soon as he did not feel he needed it anymore.

## 14 December

51. On 14 December, at around 9.10am, Mr Taylor's first ACCT review at Dartmoor took place. This was undertaken by a SO and a chaplain. The mental health team were not in attendance.

52. Mr Taylor declined mental health support on the basis that he felt much better and happier at Dartmoor. He said he did not have any thoughts of suicide or self-harm and cited his partner and son as protective factors. He said he was in the process of appealing his sentence and had writing equipment to help him do so. He also said that he felt safer in a single cell, liked the food and felt he was being treated well by staff. However, his tramadol prescription had not been transferred from Exeter. In interview, the SO told us that she got up from the review and rang healthcare, who confirmed on the telephone that they would have his medication ready by 4.00pm that day. Due to Mr Taylor's improved presentation and mood, staff and Mr Taylor agreed to close the ACCT.

53. When a mental health nurse arrived for the planned ACCT review, the SO told her that it had already taken place in her absence. The SO told the nurse that Mr Taylor's ACCT had been placed into post-closure (where it can be reopened at any point during the next seven days) because his risks had sufficiently reduced - he was happy to be at Dartmoor and denied any thoughts of suicide or self-harm.

54. The nurse decided to complete her own assessment of Mr Taylor in his cell. She recorded in Mr Taylor's medical record that the SO was under the impression that a mental health representative was not required at the review, which she had corrected her on. She was clear it was a requirement for mental health to attend all initial ACCT reviews Dartmoor. She agreed with the earlier assessment of Mr Taylor and that his ACCT should be closed. She explained the support that was available to him and told him how to re-refer himself to the mental health team if he was struggling.

## 15-17 December

55. On 15 December, staff saw Mr Taylor as part of ACCT post-closure monitoring procedures and raised no concerns.

56. On 16 December, another ACCT post-closure meeting took place for Mr Taylor and again raised no concerns. The post-closure monitoring record states, "Given morning meds. Seems in a good mood". Later that day, Mr Taylor spoke to his son on the telephone for nearly ten minutes.

57. Shortly after 3.00pm, Mr Taylor spoke to his son for around 10 minutes. We were unable to obtain a recording of the conversation, but Mr Taylor's son shared some information on the nature of the call with us following his father's death. He had told his father about potential allegations being made about him that might impact on the appeal of his sentence. Staff do not routinely listen to prisoners' calls unless a specific risk has been identified. Mr Taylor did not mention any concerns so staff.

58. At around 8.00pm, an Officer Support Grade (OSG) checked Mr Taylor through his cell observation panel during her evening routine check. In her statement, she recalled him sitting on his bed and waving and raised no concerns.

59. At 5.14am on Friday 17 December, during the morning routine check, the OSG opened the observation panel in Mr Taylor's door and shone her torch into his cell. She saw Mr Taylor slumped on the floor next to the head of his bed with a chair in front of him. She shone the torch upwards and saw there was a ligature made from a piece of towel attached to the bar on the window and that Mr Taylor was unresponsive. She immediately radioed a medical emergency 'code blue', indicating a life-threatening situation and triggering a call for an ambulance.

60. A Custodial Manager (CM) arrived in approximately 30 seconds. He cut the ligature, pulled Mr Taylor's body from the back of the cell and laid him on the floor, noting that he was cold to the touch and that rigor mortis had set in. As he began unbuttoning Mr Taylor's shirt ready to deliver first aid, an officer arrived with the defibrillator, closely followed by more staff. An officer followed the defibrillator instructions and delivered a shock when asked, but the machine told him to stop. In interview, the CM told us that it was clear Mr Taylor had been dead for some time, so staff did not attempt cardio-pulmonary resuscitation (CPR).

61. Healthcare services were not open at the time, but paramedics arrived at the cell at 5.45am and confirmed that Mr Taylor had died.

62. After Mr Taylor's death, Devon and Cornwall Police provided us with a copy of diary entries written by Mr Taylor in the week leading up to his death. On 15 December Mr Taylor wrote, "stayed awake most of the night in pain" and 16 December he wrote, "can't stand the pain enymore (sic). Nothing to do with what I am falsely accused of. Just the pain." It is unclear whether this was a reference to physical or mental pain.

## Contact with Mr Taylor's family

63. Mr Taylor had nominated his son as his next of kin. The Governor and the Family Liaison Officer visited Mr Taylor's son at his home address shortly after 1.00pm on 17 December to notify him of his father's death. Dartmoor maintained contact with Mr Taylor's family, and in line with national instructions, contributed to the costs of the funeral.

## Support for prisoners and staff

64. After Mr Taylor's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

65. The prison posted notices informing other prisoners of Mr Taylor's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Taylor's death.

## Post-mortem report

66. A post-mortem examination found that Mr Taylor died as the result of suspension by ligature (hanging). The toxicology examination found nothing significant.

# Findings

## Management of risk of suicide and self-harm

67. Prison Service Instruction (PSI) 64/2011, which contains national requirements on Assessment, Care in Custody and Teamwork (ACCT) suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. The triggers listed in the PSI include being in prison for the first time, the period after a transfer between prisons and suicidal planning. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures.

68. Staff at Exeter rightly opened ACCT procedures on 12 November 2021 when Mr Taylor was experiencing severe pain, low mood and suicidal planning. The ACCT was transferred with Mr Taylor when he moved to Dartmoor on 13 December. However, it was closed one day after his arrival when staff agreed there were no immediate risks. In interview, a SO and chaplain said Mr Taylor appeared settled and said he felt safer at Dartmoor. He said he had no thoughts of suicide or self-harm. He was worried his tramadol had not been transferred with him from Exeter but healthcare staff were able to confirm it was on its way and would arrive later in the day. Mr Taylor was happy with that, as pain relief had been the key cause of his low mood and suicidal thoughts. He was aware of the support available to him and talked about his partner and son as protective factors with whom he had regular contact. In interview, a nurse told us that after completing her own assessment of Mr Taylor, she agreed with the decision to close the ACCT.

69. We consider that the decision to close Mr Taylor's ACCT was quick, given he had recently lost his brother and had spent only one day at Dartmoor. Based on the documentation and our interviews with staff, the decision was based largely on Mr Taylor's presentation and what he said about his mood and outlook, which appeared positive. His main risk factor, the lack of pain relief, had been addressed. Staff placed Mr Taylor's ACCT in a post-closure state, to ensure review of the decision. They carried out frequent post-closure checks, did not identify any concerns and were satisfied that Mr Taylor had settled well at Dartmoor, with no reasons to suspect his risk had increased again.

70. The day before he died, Mr Taylor spoke to his son on the telephone for around 10 minutes. Mr Taylor's son told him about potential allegations being made against him, which might impact on his sentence appeal. Mr Taylor did not report any concerns to staff and therefore they had no reason to believe his risk might increase. They did not observe any signs that made them concerned. Entries in Mr Taylor's diary, found by the police after he died, talked about him not being able to 'stand the pain anymore'. We do not know if this related to physical or emotional pain.

71. Overall, we are satisfied that the decisions made in relation to Mr Taylor's ACCT and wider risk management at Dartmoor were proportionate in the circumstances. Staff had no reason to consider Mr Taylor was an increased risk to himself. We do not make a recommendation.

## Clinical care

72. The clinical reviewer concluded that Mr Taylor's clinical care at Dartmoor was of a reasonable standard and equivalent to that which he could have expected to receive in the wider community. She makes recommendations for HMP Exeter to review medication reconciliation processes.

### *Management of Mr Taylor's pain medication*

73. The clinical reviewer found issues with Mr Taylor's medication at HMP Exeter. When he arrived, Mr Taylor told staff about his chronic pain following several accidents in the community. He said he had been prescribed tramadol for some time, which helped manage the symptoms. His medical record was received two days after his reception, which confirmed his prescription. Healthcare provided alternative, weaker forms of pain relief while they reviewed the appropriateness of tramadol, which they had concerns about in a prison environment due to it being opioid based. On several occasions, Mr Taylor complained of significant pain and told staff it was impacting on his wellbeing, including wanting to die if he did not have it. Despite this, it took healthcare over four weeks to conclude that he should be prescribed tramadol. Mr Taylor had received his medication by the time he died and reported feeling positive about this. However, it was a cause for decline in his mental health over time and the assessment should have been expedited as a result. We make the following recommendation, to improve future practice:

    **The GP Lead at HMP Exeter should review prescribing processes to ensure high-risk medication assessments are completed in a timely way, with consideration of the impact on the individual**

74. The clinical reviewer noted a further issue with medication continuity when Mr Taylor was transferred from Exeter to Dartmoor on 13 December. His tramadol prescription was not transferred with him as intended. Mr Taylor missed one dose of tramadol before the prescription was provided the next day. We make no recommendation.

### *Attendance of mental health team at ACCT reviews*

75. Prison Service ACCT Policy Guidance contains mandatory actions and operational guidance for prisons delivering ACCT. It states that the ACCT Case Coordinator must ensure that healthcare staff are always invited to, or provide a written contribution to, the first case review and any subsequent case reviews where they are relevant to supporting the prisoner. It states that healthcare staff should be given sufficient advance notice of this wherever possible.

76. No healthcare representative was present at Mr Taylor's first ACCT review on 14 December. In interview, a nurse told us that a representative from the mental health team is expected to attend a prisoner's first ACCT review at Dartmoor, regardless of whether they have arrived on an open ACCT or just had one opened. There is no written local policy containing these guidelines, but she said it was a requirement that staff should be aware of.

77. A SO told us there were no representatives available in the prison at the time of Mr Taylor's first review meeting. A nurse told us that she noticed Mr Taylor was having an ACCT review and was shocked to learn that she had not been invited to attend it. She followed up with her own assessment and agreed with the decision to close

the ACCT. This proactive approach by her is recognised as good practice, which we bring to the attention of the Head of Healthcare.

78. It appears that another SO was not aware that a member of healthcare should have been invited to the ACCT review. In interview, the Head of Healthcare at Dartmoor told us that as a result of the learning from Mr Taylor's death, the prison has now changed its practice. A supervising officer now attends a morning briefing with healthcare staff. At the briefing, they discuss which ACCT reviews are due that day to make sure they are multidisciplinary. We are pleased that Dartmoor have taken steps to address the learning. As Dartmoor have already addressed the learning, we do not make a recommendation.

## Governor to note

79. We asked for a recording or summary of the call Mr Taylor made to his son the day before he died, to ascertain its relevance. Despite several requests, we did not receive the information from Dartmoor and the timeframe for retention of calls lapsed so the call was no longer available. We note that we have not experienced issues in obtaining evidence from Dartmoor in previous investigations and therefore we do not consider this a systemic issue, but bring the learning to the Governor.

## Inquest

80. The inquest into Mr Taylor's death concluded on 7 July 2025 and recorded a verdict of suicide.

**Adrian Usher**
**Prisons and Probation Ombudsman** **August 2023**

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